The European Working Time Directive: A Prescription for Regulating Junior Doctors' Working Time?

Glyndwr Rhys Lloyd

School of Social Sciences
Cardiff University

This thesis is submitted to the University of Wales in fulfilment of the requirements of candidature for the Degree of

Doctor of Philosophy

2007

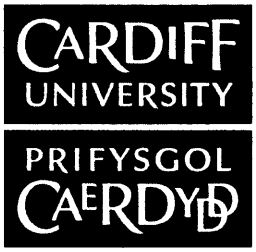
ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

The European Working Time Directive: A Prescription for Regulating Junior Doctors' Working Time?

Glyndwr Rhys Lloyd

School of Social Sciences
Cardiff University

Ph.D. 2007



DECLARATION

This work has not previously been accepted in substance for any degree and is not concurrently submitted in candidature for any degree.

Signed.....G R Lloyd.....(candidate)
Date.....18/4/08.....

STATEMENT 1

This thesis is being submitted in partial fulfilment of the requirement for the degree of Ph.D.

Signed.....G R Lloyd.....(candidate)
Date.....18/4/08.....

STATEMENT 2

This thesis is being submitted of my own independent work/investigation, except where otherwise stated. Other sources are acknowledged by footnotes giving references.

Signed.....G R Lloyd.....(candidate)
Date.....18/4/08.....

STATEMENT 3

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

Signed.....G R Lloyd.....(candidate)
Date.....18/4/08.....

Summary

This study explores attempts to regulate working time in a particular part of the medical sector. The specific focus is upon the perceptions and experiences of those in whose benefit the legislation purports to be, namely the junior doctors. It considers how the broader debates surrounding the European Working Time Directive (EWTD) are manifested in this specific section of the medical profession.

The study argues that historical modes of regulation through self-governance, professional autonomy and minimal state intervention have helped to foster opposition to the EC law among many senior doctors. Their views about working-time regulation are compared to those provided by junior doctors. This enables an assessment of the ways in which traditional self-regulation has been overtaken by subsequent forms of governance in the medical profession, namely new public management and statutory control. The accommodation in process underlines the significance of the medical profession's exclusive culture and socialisation processes. These processes facilitate the transmission of ideas on issues such as work conditions, and occupational resistance to measures such as the Directive. Conversely, the difference in attitudes between senior and junior doctors reflects the evolving nature of the profession in response to increasing in managerial authority and state intervention.

Following on from these debates, the study explores the processes by which the various modes of regulation have been implemented and enforced. It considers the respective roles played by the state, hospital managers and the medical profession, exploring the impact of working time regulation, with particular reference to doctors' health, medical training, and medical staffing and services. The study provides an assessment of the emerging impact of the regulation itself.

The study draws upon a mix of methods including semi-structured interviews with Pre-Registration House Officers and elite figures. The latter comprise policy-makers at EC, UK and devolved levels; senior figures within the medical and health services, including employer and employee representatives; and members of both the UK and European judiciary. Questionnaire surveys were also administered to all PRHOs practising in Wales.

The study concludes that a combination of factors have diluted the potential impact of the EWTD. These include the inadequate monitoring and enforcement mechanisms of a regulation whose fundamental terms have been 'fudged' by the state on the one hand, and the widespread application of a rigid shift system by the medical profession and hospital managers to junior doctors' training and service on the other. As a result, views on the EWTD are inconsistent and the degree of compliance with its provisions is variable.

List of Tables

Abbreviations

BMA.....British Medical Association

EC.....European Community

ECJ.....European Court of Justice

EWTD.....European Working Time Directive 1998

HAD.....Horizontal Amending Directive 2003

GMC.....General Medical Council

NHS.....National Health Service

NPM.....New public management

NWP.....NHS National Workforce Projects

ODP.....Operation Department Practitioners

PRHO.....Pre-Registration House Officer

RCS.....Royal College of Surgeons

RCN.....Royal College of Nursing

SHO.....Senior House Officer

WAG.....Welsh Assembly Government

Contents

Acknowledgements

First and foremost, I would like to thank the Economic and Social Research Council for supporting and funding this research. I would like to thank all the participants who gave their time throughout this project. Without their willingness, the study would have been an impossible task to undertake.

I appreciate all the support from everyone at the School of Social Sciences at Cardiff University. My special thanks to Trevor Jones and Peter Fairbrother for your consistent guidance and honesty in the appraisal of my work, and for your support and patience during the highs and lows of this study. Thanks also to Liz Renton for your assistance throughout.

Thank you to my mother, Noelle, and my father, Arwel. Words will never express how grateful I am to you for supporting me at every step. I would not have been able to this without you.

For your encouragement, thank you, Ali – a true friend and confidante with whom I have shared some great experiences over the last few years.

Finally to Catrin. *Oni bai am dy gymorth, byddai'r dasg o 'sgrifennu'r gwaith ymchwil yma wedi bod yn amhosib.*

Chapter 1

Introduction

The European Working Time Directive 1998 (EWTD) is the first general pan-European legislation aimed at regulating working hours in the European Union. Passed under Article 118a of the Treaty of Rome, it is underpinned primarily by concerns about the safety and health of workers in the EU. The Directive was implemented in the UK on 1 October 1998. Junior doctors were initially excluded from the EWTD's ambit, but amending legislation now provides them with, among other rights and entitlements, an average 48-hour weekly working limit which is to be phased in over a period ending on 31 July 2009. The interim periods impose a 58-hour week and a 56-hour week from the Augusts of 2004 and 2007, respectively. This has occurred within the context of wider debates surrounding the training and working conditions of junior doctors, and the broader strategy of National Health Service (NHS) modernisation.

Given the nature of their professional roles, the long hours associated with their work, and the underlying rationale of the Directive, one would assume that doctors would welcome these regulations. After all, the maximum working week is intended for their benefit by way of promoting better health and quality of life. The importance it attaches to the protection of NHS users by ensuring that they are not treated by exhausted doctors also conforms to the professional ethos of serving the patients' best interests. Why, then, is the regulation so controversial? The study explores this puzzle, and looks at its different facets to acquire an understanding of the outlook from which doctors argue for and against the legislation's form and content. It explores attempts to regulate working time in a particular part of the medical sector, with a specific focus upon the perceptions and experiences of those in whose benefit the legislation purports to be, and how the broader debates surrounding the EWTD are manifested in this particular segment of the medical profession.

The study argues that the historical modes of regulation through self-governance, professional autonomy and minimal state intervention have helped to foster opposition to the current EC law among many senior doctors. Ideologically, the Directive represents a centrally imposed legal control negotiated by politico-legal bargaining which is beyond the jurisdiction of UK doctors. Its failure to conform to an arrangement that is the product of internal and sector-specific discussions has led to an occupational resistance within the higher ranks of the

medical profession. The senior doctors in this study criticised the application of a monolithic form of regulation that does not take account of the concerns voiced by the medical profession, such as medical training, staffing and services. Furthermore, the Directive's weak monitoring and enforcement regimes implemented by the state provide an opportunity for some of these ideals to be manifested through the continuance of long working hours, irrespective of the legislative provisions.

Some of the junior doctors also drew upon the criticisms voiced by senior members of the profession. The EWTD, for a proportion of them, was seen as adversely affecting their ability to undertake the necessary service and education which met their professional expectations. The similarity in views between senior and junior doctors reinforced the significance of the exclusive medical culture and its socialisation processes which facilitated the transmission of ideas on issues such as work conditions, and an occupational resistance to measures such as the Directive.

The general inconsistency in the junior doctors' responses demonstrates some resistance to change within the profession and reflects some of the mixed attitudes towards EC regulation adopted by the elite informants interviewed in this study. While the prospect of better work hours, health and work-life balance influenced a pro-regulatory school of thought among many of the juniors, they perceived the EWTD as adversely affecting other facets of their work. The partial fragmentation of the medical community's outlook on external regulation, evidenced by the Pre-registration House Officers' general acceptance to work shorter hours in compliance with the EWTD, illustrated the evolving approach to work organisation among members of the medical profession. It also shows that the profession's opposition to the Directive may not be sufficiently organised to prevent the further intervention and implementation of management-led initiatives that aim to secure compliance with the regulations' provisions. This argument accords with the relevant literature that discusses the profession's diminishing authority on the one hand and the ascendancy of managerialism and state control on the other.

Having identified these themes, the study then attempts to explore the factors underpinning the differences in opinion between the informants, and the impact of the EWTD. It concludes that the discontent associated with the regulation – instances of ill health and poor work-life balance among some doctors, criticisms associated with inadequate medical training, and

difficulties related to medical staffing and services – can be attributed to the failure of the medical profession to respond to the EWTD effectively, and in line with the needs of its own members. By attempting to address juniors' working time through the widespread implementation of shift patterns, the profession and hospital management have lacked the necessary innovation to apply more appropriate systems that accommodate the specific concerns voiced by the profession. Focusing solely on the role of the regulation therefore represents a narrow interpretation of the Directive's impact, and fails to take account of the responsibility of the profession for the current state of affairs.

The criticisms raised by the medical profession in response to the EWTD echoes the discontent among its members and external commentators in relation to the profession's previous attempts at dealing with work conditions through both self-regulation and the New Deal. Other measures such as the EWTD should now be considered in light of the profession's failure to address these fundamental work conditions, together with a revision of both cultural ideals on professionalism and the delivery of medical training and services in a modernising NHS.

Rationale

My reason for focusing on the regulation of doctors' working time stems from both an academic interest in employment law and my experiences of working at a Medical School for two years prior to the commencement of the research. The latter post regularly brought me into contact with medical students and doctors of different seniorities, practicing within a variety of specialisms. Conversations with friends studying medicine and work colleagues already in the profession provided me with various insights on how doctors approached their work, including their working hours. Most of these people had heard of the EWTD and a substantial proportion had an opinion on the law, all of which ignited my interest to explore these issues in more depth and to gain a further understanding of the factors underpinning their responses. Limiting the study to analysing the attitudes of PRHOs in Wales was an example of opportunistic research, which took advantage of my existing networks and ease of access to this sample population. It also provided me with an insight into how the UK regulation process applied to a professional sector within recently devolved policies and practice.

My studying of the relevant law at undergraduate level (graduating in 2002 with a LLB in Law and Criminology) had equipped me with the necessary understanding of the Regulations' provisions and the position at common law. I was also aware of the fact that doctors had sought redress at the European Court of Justice on two different occasions as regards their working time, in addition to their average working week in the UK compared with Europe. The more material I read on the topic, the more I came to realise how controversial the application of the EWTD was in terms of implementing a standard law for junior doctors across Europe. Of particular interest was the apparent contrast between the profession's past forms of regulation, namely self-regulation and the New Deal, and the EWTD. This gave rise to the question as to whether the EC law would address the limitations of past attempts to regulate doctors' work conditions. How would the profession respond to the Directive, and to its subsequent interpretation at the European Court? Would the response shape the overall impact of the legislation? The prospect of studying contemporary regulation which was apparently dividing those whom it sought to benefit, and which could bring about certain change, was central in my decision to pursue the topic at a doctoral level.

Such a topical piece of legislation also meant that very little research was available at the initial stages of planning the study. The existing work was focused upon particular themes such as work-life, health and safety, medical training and shift work, but there was no research which brought all such issues within the parameters of one study. This research aimed to address that data lacuna, exploring long-standing debates on work regulation together with findings on individual topics to present a topical thesis on the EWTD, and its implementation in the medical sector.

Research themes

The study seeks to analyse the process and impact of legal regulation on working conditions in UK labour markets, with specific reference to the European Working Time Directive 1998 and its impact on the junior medical profession. Emerging from this general aim is a number of subordinate objectives:

1. To analyse the views of elite stakeholders about the political and legal debates surrounding the regulation of working time;

2. To examine critically the ways in which the EWTD has been implemented and enforced in practice in relation to junior doctors, and the sources of support and resistance to such processes; and,

3. To analyse the apparent impact of regulating working time on the work and lives of junior doctors.

The study explores the way in which a generic and supranational regulation affects a closely defined professional group that has hitherto enjoyed modes of regulation that are internally based and sector-specific. The first form corresponds with the tradition of voluntarism and clinical self-regulation. The second relates to the rise of managerialism in the 1980s prompted by a more interventionist state concerned with the rationalisation of healthcare (followed in recent years by clinical governance and consumerism). The third and final form of regulation is statutory, namely the EWTD. All three of these modes of regulation are now simultaneously visible in the way that junior doctors' hours are being organised. This study looks at the ways in which these different modes of regulation combine with and contest each other.

Following on from these debates, the study then explores the processes by which the various modes of regulation have been implemented and enforced in practice. This focus directs us to the respective roles of policymakers, those providing medical services, and the judiciary. The complex interaction between the stakeholders is analysed, and contextualises the tensions and collaborations as a prerequisite to evaluating the likely levels of compliance with the various modes of regulation and their consequent impact.

Exploring the experience of regulation provides different informants directly and indirectly affected by the Directive with the opportunity to discuss their perceptions of the EC law. Those debates considered most salient to the informants are examined in detail; they include the role of work time on doctors' health (Baldwin 1997; Spurgeon and Harrington 1989), work-life (Cooper at al 1989); the perceived regulatory impact on medical training (Mather 2004; Paice and Reid 2004), staffing (Fox 2007; Pickersgill 2001), and services (Scallan 2003). Some of the informants' responses corresponded to their personal degree of compliance with the Directive's provisions. Thus it was possible in some instances to gauge its impact by reference to comments made in both the interviews and the data recorded in the

surveys. In the majority of cases, however, this was not possible as many of the junior doctors provided mixed views on what they claimed to be the impact of the Directive. The final objective attempts to assess what directly flows from the regulation itself in comparison with the claims made by the study's informants. This process involved distinguishing the individual roles of the EC law, the juniors' perceptions as influenced by their peers and senior doctors, and the shift system implemented by both the profession and hospital managers. These themes are developed in the thesis's nine chapters.

The research objectives were addressed by using a mix of methods, including postal questionnaire surveys, semi-structured interviews and diaries. The diaries, completed by two PRHOs while on their respective shifts, raised my awareness of the work and issues facing juniors on a daily basis but avoiding the difficulties of observation techniques. Two surveys were conducted with different cohorts of PRHOs, the first being the 2004-05 cohort and the other comprising the 2005-06 group, all of whom were training under the direction of the Postgraduate Deanery in Wales. The surveys sought to identify and compare attitudinal patterns towards the regulation of working time in the junior medical profession immediately preceding the date for the Directive's first implementation phase in August 2004, and a year after its enforcement in August 2005.

The forty-four semi-structured interviews provide the main component of the study, and took place between the two surveys, that is August 2004 and February 2005. They were used to generate an in-depth understanding on the perceptions of those directly and indirectly involved in, or affected by the EWTD, and to contextualise the generic statistics collected in the survey. The sample is broadly categorised into two groups, namely PRHOs and elite figures. The latter comprise policymakers at EC, UK and devolved levels; senior figures within the medical and health services, including practitioners, employer and employee representatives; and, members of both the UK and European judiciary.

The original intention was to undertake a case study of junior doctors in one hospital location in Wales, but the limitations of this approach soon became apparent. For example, the nature of junior doctors' medical training allows PRHOs to divide their time between different hospital and trust sites. I therefore felt that a study focusing on a sample based at one location would not reflect doctors' variation in experiences. It became clear that the regulation of doctors' working hours at the local level was shaped by decisions taken at national, UK and

supranational levels, and it became an important objective of the study to explore these processes. More pragmatically, the level of research access required for an intensive local case study posed formidable obstacles for the researcher. In the event, it was decided to undertake a more wide-ranging study, collecting quantitative and qualitative datea regarding junior doctors in Wales, but also drawing in 'elite' perspectives from the EU and the UK as well as Wales.

Structure

This thesis is organised into nine chapters. Chapter 2 provides a discussion of the methodological approaches adopted to address these themes. It commences by contextualising the study, focusing particularly on both location and participants, before turning to the methodology and the mix of approaches adopted to gather the data. These included analysis of the existing documentary sources, the findings of which are reported in the next three chapters; semi-structured interviews; and two postal questionnaires. Electronic diaries were used to supplement this data. Issues of sampling, administration and response are discussed for each method, including their limitations in order to reflect upon the validity and reliability of the findings. It concludes with reference to the approaches used to access the elite and PRHO informants, followed by some ethical considerations provoked by the overall work.

Chapter 3 addresses the study's overarching aim of analysing the process and impact of legal regulation on working conditions in the UK labour market by summarising the historical attempts at such regulation. It also examines the tensions which have arisen in the evolving process of regulating work time in the UK through individual and collective bargaining to state intervention by way of the EWTD. It looks at the main impact of the Directive on both working conditions and employment relations in Britain as part of the study's objectives of examining the different ways in which the regulation has been implemented and enforced in practice (Deakin 2001; McIvor 1987). These debates serve to underscore the differences and similarities between the Conservative and New Labour governments (Smith and Morton 2006), while contextualising the general situation within which doctors in the UK are currently being regulated (Williams 2001; Davies 2000). They also illustrate how tensions about centralised statutory control exist outside this study's primary focus on the medical profession.

Chapter 4 provides an historical account of the different modes of regulation that have governed the medical profession's conditions of work, with reference to the broader developments in employment relations and the evolution of state intervention in the labour market. It explores the cultural and ideological bases for each form of regulation, contextualising both the tensions and collaborations between professionals, managers and the state, and their respective struggles for authority (Ham 2004; Exworthy and Halford 1999; Flynn 1999; Farnham and Horton 1996; Hood and Scott 1996; Harrison and Pollitt 1994; Freidson 1994; Pollitt 1993). Providing such an account is fundamental to our understanding of the response of the profession to external regulation such as the EWTD. This corresponds with the research objectives addressed by the study, namely to analyse the views of elite stakeholders about the political and legal debates surrounding the regulation of working time in a particular professional sector, and to examine critically the ways in which the Regulations have been implemented.

Chapter 5 explores the sector-specific debates on the regulation of working time in the UK junior medical profession (Mather 2004; Davies 2004; Scallan 2003; Davies 2000; Stacey 1992). It introduces both the New Deal and the EWTD as the two co-existing forms of control that currently govern doctors' working hours, and assesses the latter's interpretation by the European Court of Justice (ECJ). These discussions set the scene for the second part of the chapter which explores the perceived impact of the legislation, including doctors' health, medical training, and medical staffing and services. The profession's responses to these, particularly if they are supported by the study's findings reported in the latter chapters, indicate the levels of EWTD compliance among junior doctors in the NHS. The chapter therefore attempts to provide a context within which it is possible to assess the impact of regulating work time on the work and lives of junior doctors. This corresponds to the third research objective, while setting the scene for the exploration of viewpoints provided by informants in later chapters.

Chapter 6 is the first of three which presents the findings arising from the primary data collection phase of the study. It explores the perceptions of elite groups on the issue of regulation, with specific reference to the EWTD, drawing upon qualitative data gathered from policymakers, medical service providers, and the judiciary. This relates to the first objective listed above: to analyse the views of elite stakeholders about the political and legal debates

surrounding the regulation of working time. It maps the profession's sequential modes of regulation and the limitations apparent in each model to explain why the informants initially embraced a Directive that represents a form of centralised control, and which contrasts significantly with their historical forms of self-governance. It then explores the impact of intervention of the European Court of Justice which has subsequently shaped a marked opposition among elite figures towards the legislation. This has given rise to the paradoxical situation in which doctors, as participants in a health-based profession, vehemently criticise a measure interpreted by the judiciary in such a way that explicitly prioritises their health.

Chapter 7 bridges the broader arguments surrounding the regulation of the medical profession with the experiences of doctors and their managers at a hospital level. In line with the study's second objective, it aims to examine critically the ways in which the EWTD has been implemented and enforced in practice, and the sources of support and resistance to such processes. It analyses the roles of the state and managers in the implementation of the Directive, and explores how the process has shaped regulatory compliance with the current limits in addition to how it may affect the stricter provisions in 2009. The chapter then assesses the monitoring and enforcement regimes which operate alongside attempts to apply EWTD-compliant work strategies in the medical profession. It concludes with a discussion on the interaction between junior and senior doctors and their managers to analyse how each of them support and resist the processes implementing the Directive.

Chapter 8 explores the impact of regulating working time on the work and lives of junior doctors, with specific reference to the European Working Time Directive, in line with the third research objective. It does so by looking at the claims made by both junior and senior members of the medical profession on what they perceive to be the regulatory impact on their life within and outside work. They are organised thematically under the topics of health and work-life, medical training, and medical staffing and services, and include discussions on the significance of the widely used shift systems to ascertain the impact of factors unrelated to the regulation. The views of junior doctors surrounding the issue of regulation are also explored to gauge the consistency in opinion between senior and junior members of the medical profession, and to assess whether this will shape the way in which the latter approach their work in a way that complies with the EWTD.

The final chapter concludes with an overview of the study's findings and discusses some of the wider themes raised by the research, including the role of law as a regulator of workplace relations.

Chapter 2
Research Methods

Introduction

It is conventional to locate discussions on methodology immediately before the chapters that report the fieldwork. Analysis of the existing literature in chapters 3, 4 and 5, however, also constitute a method of gathering data which provide the basis for development of the study's key research themes. This chapter provides a discussion of the methodological approaches adopted to address these themes, elaborating on what is discussed in Chapter 1. It commences by contextualising the study and focusing particularly on both location and participants, before turning to the methodology and the mix of approaches used to gather the data. This includes primarily reviews of the existing research including secondary data analysis, followed by considerations raised by the use of semi-structured interviews and two postal questionnaires. This data was supplemented by a small amount of information gathered from electronic diaries by two junior doctors. Issues of sampling, administration and response are discussed for each method, including their limitations, in order to reflect upon the validity and reliability of the findings. The chapter concludes with reference to the approaches used to access the elites and PRHOs, followed by some ethical considerations provoked by the overall work.

Context

This study broadly aims to analyse the process and impact of legal regulation on working conditions in UK labour markets, with specific reference to the European Working Time Directive 1998 and its impact on the junior medical profession. Emerging from this general aim is a number of objectives which this study attempts to address:

1. To analyse the views of elite stakeholders about the political and legal debates surrounding the regulation of working time;

2. To examine critically the ways in which the EWTD has been implemented and enforced in practice in relation to junior doctors, and the sources of support and resistance to such processes; and,

3. To analyse the apparent impact of regulating working time on the work and lives of junior doctors.

The study explores attempts to regulate working time in a particular part of the medical sector, focusing upon the perceptions and experiences of those in whose benefit the legislation purports to be, and how the broader debates surrounding the European Working Time Directive are manifested in this segment of the medical profession. It examines the ways in which a generic and supranational law affects a closely defined professional group that has hitherto enjoyed modes of regulation that are internal and sector-specific. The processes of implementing the various modes of regulation are considered by looking at the respective roles of policymakers, those involved in the provision of medical services and the judiciary.

The focus of the study on junior doctors, and on PRHOs in particular, emerges from concerns reported in the literature on the EWTD's implications on their health and safety and medical training. The generally poor health among PRHOs is well documented (chapter 5), and so it was anticipated that the Directive would deliver real changes to their work and life quality. However, this segment of the profession is also adapting from the strictures of medical school to the labour market, and commencing their long and demanding medical training. The educational perspective is therefore perceived by them as an important aspect of their work but this has been associated with long working hours (and has, to a degree, fuelled ill health). The study therefore explores these tensions that involve junior doctors, and which are set against the broader ideological debates surrounding the state's direction towards more centralised modes of regulation and away from the medical profession's historical trends of self-governance. By reference to the general literature and the data gathered from both the surveys and interviews, the study attempts to assess the impact of the EWTD.

The decision not to confine this study to the analysis of a single hospital site was related to the objective to explore the experiences of junior doctors as broadly as possible. Their PRHO year is divided into two composites, during which they spend time training in different medical specialties and often in different hospitals. The Foundation programme, which has recently replaced the PRHO and Senior House Officer (SHO) years, is similarly split into two years of training – F1 and F2 – with each year divided into three medical specialities lasting four months each; both years can be spent at different hospitals. Thus conducting a study

based at one hospital or NHS trust would not have reflected the doctors' variation in experiences.

The richness of the data gathered from the nine junior doctor informants working at different hospital sites was reflected in their different experiences of work organisation under the EWTD. The study's focus was able to highlight the inconsistent implementation, enforcement and compliance with the Directive's provisions not only between different trusts and specialties, but also between EC Member States. It was also able to underscore the degree of inconsistency in views held by both senior and junior members of the medical profession. In hindsight, had the focus been confined to either Wales or a single hospital or trust site, the study would not have necessarily identified some of these differences. As a result, it may not have elicited the necessary data to correspond with the research themes.

The study's elite informants – policymakers, medical service providers, and the judiciary – come from across the UK and parts of Europe. Partly as a result, some of these their claims related to a mix of both their individual and specific experiences of work regulation, and the more centralised and general views represented by their organisations. It was therefore difficult to define the study's boundaries not only by reference to the individual hospital site or NHS trust, but also to the context in Wales. The views of many doctor informants – both junior and senior – notably perceived themselves as representing the views from a UK rather than from a Welsh perspective. This may be attributable to the centrally governed nature of their profession. Many of them were also unaware of any differences as regards the situation in Wales compared to the UK.

Nonetheless, there are distinctly 'Welsh' issues that should be considered, and these have been noted accordingly. Examples include policy divergence between England and Wales on issues such as free prescriptions and the use of private facilities, and notably the opposition by the devolved governments in both Scotland and Wales to the establishment of NHS Foundation Hospitals (chapter 4). The Welsh Assembly government plays a role in monitoring the overall implementation of the Directive, collating information and disseminating best practice but, like England, leaves the issue of enforcement to the relevant central authorities. In line with the state's general intervention with the employment relationship, negotiations regarding individual conditions of work are privy to the employees

and their employers, though they are constrained by a series of basic rights contained in UK-wide regulations.

As discussed in chapter 4, devolution has not significantly affected the national frameworks that exist to regulate the working time of junior doctors. NHS trusts are obliged to comply with the provisions contained in both the New Deal and the EWTD in arranging doctors' rotas. The latter's other general terms and conditions are determined centrally by national bargaining conducted almost exclusively by the BMA and the government. The medical profession's remuneration in the NHS is also centrally decided by the state, which takes into account the recommendations made by the Review Body on Doctors' and Dentists' Remuneration (DDRB). The Welsh Assembly government does have a presence in Brussels and interviews for this study were carried out there, but its role in dealing with doctors' labour conditions is severely restricted as Whitehall negotiates with other Member States on the issue. While devolution has therefore had a limited impact in the short term, this study does not rule out the potential differences that could emerge in the longer term.

Methodology

One's perspectives on the qualitative and quantitative paradigms often shape the character of the research (Bryman 1992). Methodological rifts between the two concepts continue to permeate text books on research methods (for example, Jones 2004; Smith and Hershusius 1986):

> Quantitative research is associated with a belief in the objectivity of the social world, and the idea of causation in social processes. This is linked to the belief that social research can draw on the methods of the physical sciences, in particular the use of numbers to measure the relationship between 'things'. Qualitative research tends to be associated with the idea that social life is the product of social interaction and the beliefs of actors, that the social world is not populated by things, but by relationships and actions.
>
> David and Sutton 2004: 36.

Having regard to the debates associated with each paradigm, the predominant strategy followed in this study was to consider the feasibility of conducting work that would best

address the research themes, taking into account the demands of cost, time and administration, in addition to my access to the informants. As a result, no more priority was given to positivistic techniques than to more constructionist models:

> employing a range of methodological strategies means that the researcher does not necessarily privilege a particular way of looking at the social world.
>
> Philip 1998: 261.

The study's methodological strategies included a mix of methods including postal questionnaire surveys, semi-structured interviews and diaries. The first sought to both identify attitudinal patterns towards the regulation of working time in the junior medical profession and to obtain a sample of interviewees. The interviews, designed to contextualise the generic statistics, provided the main component of the research to generate an overall understanding on the doctors' perceptions and experiences of the EWTD. Finally, two electronic diaries carried around the hospital by two PRHOs raised my awareness of their work and typical issues facing them on a routine basis. In transcending the narrow qualitative/quantitative classifications, the decision to gather data from both a range of methods therefore attempts to avoid arbitrary categorisations between qualitative and quantitative research:

> all social research relies upon qualitative and quantitative aspects...The dispute between quality and quantity in social research obscures the fact that there is always a degree of quantification in any form of qualitative research and there must be a qualitative dimension in any attempt at quantitative research. All research is qualitative and quantitative.
>
> David and Sutton 2004: 39.

While mixed methods may be a more effective approach from which it is possible to draw conclusions and causal inferences, Spicer (2004: 297-98) points out that it is often based on the "naïve realist assumption that a single, fixed and coherent reality can be converged on through the use of more than one method". That data can be corroborated and authenticated only because the researcher adopts the triangulation technique is misguided; different findings are likely to emerge (and be subsequently interpreted) from different research methods. Furthermore, even if research employing a package of methods generates consistent

findings, it is by no means certain that an additional method would not reveal different, contradictory findings. While triangulation has become more popular among social scientists, it therefore remains important that the researcher understands that there are differences in the qualitative and quantitative mediums:

> If integrated research became increasingly popular, it is possible that some investigators which combine quantitative and qualitative research would be undertaken in such a way that it is difficult to detect what advantages have accrued or even what advantages the investigator anticipated.
>
> Bryman 1992: 508.

Despite these limitations to triangulation, it was felt that the mixed method approach of this study did produce robust findings that addressed the key research themes. However, some decisions were taken at the initial stages of the study which have, in some respects, limited the findings. The use of survey and interview methods were considered satisfactory medium to address the research themes posed by the study, while acknowledging the practical considerations of cost and time. A postal questionnaire confined to PRHOs in Wales conformed to all these factors. The ease of accessing this particular population also shaped my decision to restrict the number of surveys. A second wave of identical questionnaires were posted a year after the first cohort and found very few differences in responses, which suggests that extending the survey sample beyond junior doctors in Wales to a UK-wide survey would not have added any substantially new findings to those reported in this study. Furthermore, there are seventeen Deaneries in total, including Wales. Guaranteeing similar cooperation from and the necessary access to, the same information that was obtained in Wales from the other sixteen Deaneries was not possible in the time available.

The decision not to undertake research of an ethnographic nature partly reflected the concerns surrounding time and access. Early discussions with key informants indicated that there would be major difficulties in gaining access to a politicised setting such as the NHS to observe PRHOs at work. The process would have involved acquiring the key support of the PRHOs being observed, in addition to their medical and healthcare team members and patients. Of more importance, however, the emphasis placed on intimate settings by the ethnographic approaches, including their subjective focus on time, place, social circumstances and language (Kirk and Miller 1986), were not perceived as the most

appropriate methods of addressing the research objectives of this particular study. The practical limitations and demands of time spent with relatively small groups of people in order to understand the social milieu which they inhabit would not adequately deal with a study focussed on large-scale cases such as big organisations (Hammersley and Atkinson 1983). This would have directed the study away from the broader analysis of debates surrounding the regulation of a centrally organised medical profession, operating within a National Health Service. It was therefore felt that the objectives would be best addressed through the use of semi-structured interviews and questionnaire surveys with the Wales Deanery providing the PRHOs, and the senior medical staff and policymakers, as well as judicial informants necessarily coming from Wales, the UK and the EU.

Reviewing existing research

As the first key stage in the research, much time was initially spent analysing documents and other secondary sources on subjects related to the EWTD and other forms of regulation. The study attempts to incorporate a number of broad debates relating to working-time regulation, which is discussed below. With the aim to address as many of the primary and relevant debates as possible, it quickly became apparent at the initial stages of the study that wide-ranging sources of literature were available. The M.Sc. dissertation had already identified some of these in preparation for the doctoral study. As a result, parts of the analysis explores existing research looking into factors directly related to the EWTD, such as doctors' health, work-life, medical training, medical services and staffing. However, it was also necessary to review some of the broader debates to contextualise the overall study and its findings.

In this respect, the contribution of both this study and research method in particular is two-fold. First, on a micro level, it addresses a lacuna in the existing academic research on work time legislation from the perspective of the general labour market in the UK and from the specific view of the junior medical profession in the NHS. At the time of writing, there was a distinct lack of research that focused on the formation, implementation, enforcement and impact of such regulation on these sectors which incorporated a balance of both qualitative and quantitative methods of data collection. Individual themes were discussed in different literature. For example, the medical literature focused intensely on the perceived impact of the legislation on professional training, whereas other health-based research considered the effect of such regulation on health and work-life. This study attempts to address the apparent

'gap' in the existing research by consolidating as many of these concerns within the confines of one project.

Secondly, and related to the first point, the study on a macro level locates the available discussions on the EWTD within the broader theoretical debates applicable to employment relations and regulation. These can be classed into three groups, which have been explored using secondary data analysis as a method in itself. The first group of debates comprises literature reviews on workplace relations in the UK, focusing on the longstanding tensions between voluntarism and collective bargaining on the one hand, and centralised state regulation on the other. The study applies these theories to the present context by arguing that historical forms of regulation are very apparent in the way that legislation is formed, implemented, enforced and subsequently perceived in the UK today, particularly so in the junior medical profession. The EWTD is a prime example of a minimalist regulation which contains numerous exemptions and derogation and whose enforcement is critically under-resourced (see chapter 3) which has subsequently contributed to instances of non-compliance. The State has therefore adopted a particular stance on the EWTD which is closely associated with its traditional voluntarist approach to regulation.

The second broad debate discussed in the study is the development of New Public Management (NPM) and rationalisation policies applied initially by the Conservative government in 1979 within the public sector labour market including the NHS (see chapter 4). This literature is equally as applicable to the current circumstances in which the EWTD has been implemented as it reinforces the increasing authority of management, as agents of the State, over the medical profession. It represents a further encroachment on the working autonomy to which doctors have historically been accustomed. The rise in managerialism and regulation has inevitably conflicted with the self-regulatory nature of the profession. This study argues that this tension may have been reflected in doctors' responses towards the law.

The third general contribution towards the current debate is regulation theory, and the questions it raises in respect of the limits of law as a tool to govern social behaviour (see chapter 9). The study shows an attempt, via the EWTD, to control an area of social life by a highly centralised statute which has historically been regulated in less formal ways. The outcome of this study will therefore determine if law is the most effective way of dealing with specific working environments, and whether it serves as more of a symbolic rather than

instrumental statement that is able to actually effect change. This argument is approached by reference to the ambiguous terms of the legislation which has been written by the state legislature, and which has consequently provided the space to implement and enforce the regulation in an inconsistent manner.

Both the micro and macro aspects of this study's contribution, and its references to the specific debates in the medical profession in addition to the broader discussions associated with regulation, are addressed by the author's investigation of the existing research. The findings of documentary analysis are reported in the next three chapters, and are subsequently assessed in light of the study's findings in chapters 6, 7, and 8. The next three chapters are therefore integral to one's understanding of how the various debates are inter-linked. They also provide necessary background detail which allows the reader to comprehend the contribution that this study is making to the existing literature, and to locate its relevance within both the broader and more specific debates:

> The aim in doing this is to place your own work within an existing research context, for example, the kinds of theories which have underpinned the key writers in the chosen field and the methodological questions they raise...Through doing this search and intensive reading, gaps and lacunae in existing research can be identified.
>
> Gray 2003: 59.

The findings which are reported in the next three chapters arise from a detailed review of secondary sources (including academic papers, government reports and other published reports and statistics) conducted by the author using academic journals, legislation, case law and a very wide range of authors which address the present lacuna in data referred to by Gray (2003).

This process provides a further example of how this study has attempted to triangulate the available data using a combination of documentary and secondary data analysis with primary data collected by way of semi-structured interviews and the postal questionnaire surveys. The secondary research provides informed reference points to which the later findings form the primary data collection phase can be compared and understood. This interaction also provides the critical ability of corroborating and augmenting evidence from a variety of sources (Yin

1981). As a result, the incorporation of both primary and secondary data sources allow for exploration and greater insight into the lives of those studied, exploiting the strengths of the mixed methods approach.

The process of locating documentary sources, both official and unofficial, involved the use of broad and more specific search terms (such as regulation, EWTD, medical, profession, industrial relations, and work time, used individually and in various combinations) in the 'Voyager' library cataloguing service and the larger on-line databases such as Ingenta.

In addition to identifying key authors and text books, the searches also identified a number of journals which commonly featured articles on particular themes. They included the *British Journal of Industrial Relations*; the *British Medical Journal*; *Industrial Law Journal*; *Law and Policy*; and, *Sociology of Health & Illness*, to name a few. The research published by the Department of Health, the (then) Department of Trade and Industry, the TUC and the BMA provided the necessary information on the broad policy debates and national data in the UK to further contextualise the study. The European material was taken from the EU databases and the Industrial Relations Observatory Online (http://www.eiro.eurofound.ie) in particular. The topical nature of the study's focus meant that reports, revisions, consultations and case-law regarding the EWTD were regularly being produced; similar changes were occurring within the medical training system. In addition to using the sources discussed above, other search engines were used to ensure that the study was kept up to date. They included the BBC Online (http://www.bbc.co.uk/news), the use of legal databases, such as Nexis-Lexis Butterworths and Westlaw, and European sources documenting the relevant EC political and legal developments (http://ec.europa.eu/prelex).

The overall process of reviewing existing research provided, on the one hand, an understanding of the issues facing junior doctors, and on the other, it highlighted the methodological strengths and weaknesses of existing studies. These reviews subsequently helped to shape the current study's research themes, and introduced the methods chosen to address them:

> To determine the questions that are most significant for a topic, and to gain some precision in formulating these questions, requires much preparation. One way is to

> review the literature...experienced investigators review previous research to develop sharper and more insightful 'questions' about the topic.
>
> Yin 1994: 9.

Problems of 'data overload' emerged early in my writing of relevant, albeit very long chapters that reviewed the relevant research literatures. It was recognised that difficulties in drafting literature reviews before the data collection stage could lead the research to veer from its original aims and objectives. In a similar respect, fieldwork could influence and sometimes change the orientation, questions and method of the research, placing doubt on earlier literature reviews (Branley 2004). To limit this potential problem, and in preparation for the questionnaire survey, a set of initial interviews were conducted with some key figures to gain a better understanding of the most relevant and salient issues facing the medical profession. These exercises, which included semi-structured interviews with a senior clinician, a BMA regional representative and two PRHOs, retained my general focus on the research themes and helped to identify the relevant materials of the literature reviews. Combining these experiences eventually allowed me to piece together a working draft survey encapsulating all the issues that conformed to my aims and objectives.

Semi-structured interviews

Interviews in social research entail an interviewer and interviewee attempting to develop a shared understanding of a particular topic (Yates 2004). The flexibility associated with the more qualitative semi-structure interview method adopted for this research elevated the involvement and participatory role of the interviewees, and allowed them to discuss the issues that they considered most salient. In turn, this reduced the effect of interviewer bias and prejudgements of what constituted the most relevant line of enquiry:

> For in [the structured methods] interviewers have already predicted, in detail, what is relevant and meaningful to their respondents about the research topic; and in doing this they have significantly prestructured the direction of enquiry within their own frame of reference in ways that give little time and space for their respondents to elaborate their own.
>
> Jones 2004: 258.

The less structured approach to interviews provides for the informant's a 'voice' to be heard; there is far greater room to explore the interviewee's point of view, and his or her representations and accounts. The very nature of an exploratory exercise also allows for an insight into voices and experiences which they believe have been ignored, misrepresented or suppressed in the past (Byrne 2004). PRHOs arguably fall within this category even though they have the status of professionals because of their junior position and lack of empowerment (Lowry 1993). Democratising 'suppressed' views by interview methods does, however, have limitations insofar as time and cost preclude their widespread use, making the data difficult to extrapolate and to subsequently generalise beyond the confines of the study. Moreover, given that the exercise is prepared, conducted and analysed by the researcher, subjective interpretation of the data raises the possibility that if he or she was substituted for another then the study's findings may well come to a different conclusion.

As the primary method of the study, the interview sought to gain a more in-depth and contextual understanding of the EWTD among policymakers, medical service providers, and the judiciary. Its semi-structured format incorporated methodological components ranging from a closed questionnaire to an open 'conversation', thus attempting to attain a degree of standardisation on the themes identified between the existing empirical research and those provided by the informants. It was felt that adopting a more structured design would not only restrict the interviewees' responses, but would duplicate the information already gathered in the survey. The forty-four interviewees can be grouped into the following categories: policy-makers; those involved with providing medical services (including employer and employee representatives); and, the judiciary. They are listed as follows:

Policymakers (11)

- The Welsh Local Government Authority;
- The Junior Doctor Coordinator at the National Assembly of Wales;
- The Chief Medical Officer at the National Assembly for Wales;
- Two MEPs, representing Labour and the Conservative parties,
- Assembly Member, Plaid Cymru (and GP);
- The National Assembly for Wales' delegates in Brussels;
- Two spokesmen from the Department of Health (DH) and Modernising Medical Careers (MMC);
- The Health and Safety Executive (HSE); and,
- An EC Commissioner;

Medical Services (33)

- Eight full-time and one part-time PRHOs (5 females and 4 males);
- A Medical Director of an NHS trust;
- A Dean of Medicine;
- A Vice Dean of Postgraduate studies of a Medical School and consultant of Palliative Care;
- A Vice Dean of Undergraduate Studies at a Medical School;
- The Director and Dean for Postgraduate Dental and Medical Education for Wales;
- The Dean for Flexible Training;
- A consultant anaesthetist;
- A consultant occupation physician;
- A consultant surgeon;
- A Professor and Honorary consultant in paediatrics;
- A Medical School Admissions tutor and consultant in haematology;
- Head of Postgraduate Recruitment and Widening Access at a Medical School;
- Undergraduate medical student and NUS President;
- Undergraduate nursing student;
- Three prospective medical students;
- Members of the allied professions (a nurse, physiotherapist and occupational therapist);
- An operating department practitioner;
- The Deputy Chairman of the Junior Doctor Committee and Chairman of the Working Hours Sub-committee of the BMA (and GP);
- A chairman on the EWTD steering group at the Royal College of Surgeons (RCS);
- A representative of the NHS Confederation;
- The Royal College of Nursing (RCN); and,
- Senior Medical Staffing Manager

Judiciary (2)

- An Advocate General at the European Court of Justice at Luxembourg; and,
- An ex-ECJ judge presiding for the UK.

The classification, however, has its limitations insofar as there is a significant degree of cross-over between some of the informants' roles. The Assembly Member for example is both a politician and a GP; the Deputy Chairman of the BMA is also a GP; whereas the Vice Dean of postgraduate studies of a medical school is also an active member at the House of Lords and a consultant in palliative care. On numerous occasions, an informant from one group was therefore sufficiently qualified and experienced to talk from a perspective of another group. This had its advantages in my use of 'snowball sampling', which is discussed below. With the exception of the PRHOs, the prospective medical students and, to a certain extent, the members of the allied health professions, the interviewees comprised generally 'elite' stakeholders. Elites can be loosely defined as those with close proximity to power or policymaking (Lilleker 2003). They are a powerful, talented and privileged in society (Zuckerman 1972).

Looking at these relatively straightforward categories, the different groups of interviewees can be linked to the particular research objectives that guide the study. The analysis of the elites' views about the political and legal debates surrounding the regulation of working time reflects the study's first objective. Attempts to critically examine the implementation, enforcement and the consequent sources of support and resistance for the regulations can also be gauged by their responses. The views of the PRHOs together with those of the senior medical providers correspond to the third objective of analysing the emergent impact of regulating working time on the work and lives of junior doctors.

The interview schedules between elite and non-elite interviewees differed according to the information with which they could individually provide me, and were shaped by the research objectives. Preparation was therefore important prior to the interview (McHugh 1994) and, for the elites, research was carried out on most of the individuals' backgrounds through their published materials, biographical details contained on the internet, and by cross-referencing information from other interviews. These processes enabled me to draw up a list of appropriate questions. Overall, the schedules, in line with the interview format which was adopted, were structured loosely to permit subsequent comparisons between the answers provided. The PRHOs' schedule was as follows:

- **General conditions of work in the NHS**

What is it like to work there, as a doctor?

- **Working time**

Work hours and monitoring in practice; does this exceed their contracted hours?
If so, explain longer hours and discuss relevance of professional expectations / culture

- **Time spent at hospital**

Views on time spent committed to service and medical training;
Willingness to take time off and relations with managers;

- **Health**

Personal experiences of poor health, if any, and relevance of working time.

- **Work-life & flexible training**

Personal experiences and relevance of salary (would they work longer hours?)

- **The EWTD**

Most salient issue; should doctors be exempt? Is 48 hours per week realistic?

The effect of asking such questions was to obtain subjective views about the apparent impact of regulating working time on the work and lives of junior doctors, in line with the third objective of this study. Drawing upon personal experiences contextualised the regulatory issues discussed in the literature on a distinctly local level. Their responses informed the study of the most salient debates (thereby reducing the effect of researcher bias), and illustrated the degree of regulatory compliance among junior doctors, their senior counterparts and the trusts, as employers. Together with the survey findings, the issues raised by the PRHO interviewees were corroborated by the elite informants, and used as a basis to relate the broader regulatory debates with what was being discussed and implemented at a micro level.

Elites can soon detect whether questions are standardised or tailored to their interests and histories, and begrudge being encased by standard lines of enquiry (Zucherman 1972). For this study, certain questions were therefore earmarked for all informants, but each schedule included particular questions for each individual elite. For example, the acting Director of the Modernisation Agency at the Department of Health was asked about the implementation of the pilot programmes as a means of applying the Directive in different medical specialities and NHS Trusts. The interview with the consultant occupation physician centred largely on the health of the doctors and the perceived impact of the EWTD (including the role of shift patterns) to corroborate the concerns of junior doctors, but also to explore the issue of health among senior doctors. The supranational roles of the EC legislature and the ECJ were discussed in more depth by the EC Commissioner and the Advocate General of the European Court, respectively as part of the broader context facing Member States' health systems.

'Professional preparation' for the PRHO year formed the core themes of the interviews with the various Deans of the Medical School, in addition to the rise in female medical graduates and its perceived impact on both the general medical workforce and on the NHS. The questions directed to the Dean for Flexible Training specifically covered these issues. The Senior Policy Adviser at the HSE was inevitably asked about the enforcement regime in place for the EWTD, whereas the Senior Medical Staffing Manager was asked about the implementation of the legislation within the context of such a regime. Interviews with the Manager of Widening Access and a Medical Schools admissions tutor explored the

backgrounds of medical students, as a prerequisite to looking at how these factors shaped the medical profession. Like the PRHOs' interviews, however, the following themes and sub-questions formed the core of each of the elites' interview schedules:

- **Working Time**
  - How did the working hours reported in the study's survey correspond to their experiences of the time spent by junior doctors at hospital?
  - Was there a long hours' culture in the medical profession, and how would the EWTD address this?
- **EWTD Impact**
  - What were their views on the health rationale of the EWTD?
  - Impact on training
  - Was compliance with the EWTD's phased limits possible, and what was their experience of regulatory compliance among the profession and employers?
  - Views on ECJ case law and the definition of working time
- **EWTD Implementation**
  - The implementation of the EWTD through shift system: what were the effects?
  - What was the state of Government preparation and guidance?
- **Regulation**
  - How did the EWTD fit into the broader context of regulating the medical profession (with particular reference to the historical modes of self-regulation and the more recent New Deal)?
  - What is the most appropriate body to regulate working time, drawing from their experiences of centralised negotiation by the BMA, governmental agreements such as the New Deal, and now the EWTD?
  - Exclusion of doctors from EWTD

The elites' schedule is therefore different from that adopted for junior doctors, largely because of its emphasis of elevating debates to the broader professional, national and supranational context. This corresponded to the research objectives of analysing the views of elite stakeholders about the political and legal debates surrounding the regulation of working time, and to examine critically the ways in which the EWTD has been implemented and enforced in practice, and the sources of support and resistance to such processes.

The sample of 'elite' interviewees was drawn up during the literature reviews, and through informal networking with individual informants. A number of them suggested that I seek the views of another named person, thus giving effect to a form of 'snowball' sampling. This was particularly the case for contacting individuals in Europe and in the medical profession. Many of the senior informants held more than one post and worked, for example, both in academia and as a clinician and/or in policymaking. This allowed me to capture the views of

individuals representing 'two sides of the coin.' The overall experience of sampling therefore made it easier to access the figures appearing on the interviewee list. The fact that they had a dual role essentially meant that their names and responsibilities were known by a wider audience within the confines of a relatively closed professional group.

Only three elite sources declined to be interviewed. The first was the Medical Defence Union (MDU). Despite assurances of confidentiality, they were reluctant to discuss any confidential and litigious issues with external individuals and agencies. The second and third potential interviewees were an ex-ECJ Judge representing the UK, who gave judgment at the European Court of Justice in the early EWTD cases, and the Senior Policy Advisor for the HSE. Both, however, provided helpful written responses to the interview schedules that were electronically mailed to them.

A total of nineteen PRHOs provided me with their contact details at the end of the first survey indicating that they wished to further participate in the research. Of that figure, nine responded to a follow-up letter requesting an interview and/or a dictaphone diary. Seven subsequently attended interviews at different dates and two juniors registered interest in the diaries. A poster was sent to every doctors' mess (a common room) in hospitals across Wales from which two responded and later attended an interview. Doctors E and F are the only two from either cohort of PRHOs whose views were sought by all three methods.

The names appearing on the overall interview list were approached midway through the first year of the research (while administering the survey for the first cohort of PRHOs) in anticipation of the difficulties in accessing 'elite' informants. The intervening period between the two surveys – August 2004 to February 2005 – was fully occupied with interviewing. Undertaking forty-four interviews within a short timescale was at times demanding given that the process of interviewing, transcribing and analysis were being attempted simultaneously. The results of the first survey had to be addressed and subsequently evaluated, and preparation for the survey to the second PRHO cohort took place at the same time. The interviews were conducted in a variety of public and private settings. While aware that the consistency in responses may be shaped by the different locations, the relatively coherent comments which were gathered suggest that the informants were not adversely affected by this factor. Rather, the onus was on myself to respect the wishes of the interviewees as to the location of the interview, and to elicit the optimum responses irrespective of the setting:

> It is important for the researcher to identify a time and a place where the interviewee is going to feel comfortable ...
>
> David and Sutton 2004: 90.

Methodologically, the key difference between both the private and public places was their implications on the quality of tape recording and the subsequent difficulties involved in their transcription. This was particularly the case as regards the background noise at some of the public settings. A tape recorder was used in most of the interviews allowing me to concentrate on the interviewees' responses. In turn I was able to probe either for clarification or to expand on the answer without having to take written notes:

> Qualitative interviewing is a skilled process as you need to develop the ability to listen carefully to what you are being told at the same time you consider how to take the interview forward and what your next question will be.
>
> Byrne 2004: 190.

A tape recorder was found to have the added advantage of minimising the possibility of distorting the informants' answers and of reducing error. Note-taking restricted some essential components of the interview such as visual and semi-verbal cues that would ordinarily contribute to the development of a good rapport. Some of the literature discusses the issue of elites' requests for their comments to be treated 'off the record' (Lilleker 2003). This was particularly the case for the civil servants at the Welsh Assembly government who were bound under the Official Secrets legislation, and the Advocate general at the ECJ. Welch *et al.* (2002) found that the business elites in their study answered some questions in a guarded fashion because of fears that their comments may be used against them. The majority of elite interviewees in this study, however, appeared unaffected by the device presumably because their positions meant that they were used to being recorded (Ball 1994). Doctor B was the only non-elite who showed some anxiety about being recorded and identified in the research process. In order to allay the informants' concerns, the anonymity of each interviewee – elite and non-elite – was guaranteed both in writing (in the correspondence before the interview), and verbally at the commencement of the meeting. Transcription took between two to three hours per interview with the longest interview taking an hour and a half

(Dr C) and the shortest being approximately fifteen minutes (the consultant in palliative care and the Medical Director).

Gender is inevitably an important issue to consider in interviewing, but it is difficult to generalise about the precise nature of its importance (Johnston 2001), simply because very little research has focused on the ways gender differences frame or influence the research findings (Bryman 2001). Some research questions may elicit responses or perspectives for which gender has great relevance in response (Cotterill 1992), whereas others may not. The same would apply to factors such as race, class, age or other characteristics (David and Sutton 2004). Feminists such as Oakley (1981) have regarded the interview as a situation in which women should be able to feel comfortable to tell their own story as they see it. The interviewer should not dominate the direction and the agenda of the interview (Puwar 1997), and much emphasis is placed on establishing empathy, trust and ethics (Finch 1984) typically using in-depth and unstructured interviews. It departs from the conventional mode of interviewing which has attracted feminist critique:

> The traditional interview is seen not only as paternalistic, condescending in its attitudes towards women and not counting for gendered differences, but also as based on a hierarchical relationship with the respondent in a subordinate position.
>
> Punch 2005: 173.

The feminist model is therefore based on reciprocity and intimacy, aiming to produce non-hierarchical, non-manipulative research relationships which have the potential to overcome the separation between the researcher and the researched. This is in contrast to the elite interviews in which elites assume interviewers are like journalists, who are to be manipulated or used but never trusted (Rubin and Rubin 1995). Furthermore, the time constraints imposed on elite interviews make it difficult for the researcher to build a relationship of trust.

It is therefore important to think about how the researcher's characteristics might enhance or intrude on data collection. The feminist critique would advocate minimising status differences between interviewer and respondent, and developing a more equal relationship, enabling greater openness and insight, and richer data (Denzin and Lincoln 1994). While interviewer effects must be acknowledged and controlled if they endanger the validity and reliability of response, there are limits to the extent of matching which can be achieved, not

least by the labour-market conditions and administrative demands (Hyman *et al.* 1954). For some, the desirability of such an approach is also doubted. Lewis (2003), for example, argues that in studies on sensitive issues, people may find it more helpful to speak with someone who is outside their own community or population group. Matching the interviewer and informant is not always a useful approach. There is a risk that similarities between interviewers and interviewees will preclude effective communications, and the elicitation of rich data:

> Interviewing people similar to yourself can pose difficulties, because the interviewees assume that you know what they know evidence suggests that interviewing across class, gender, or ethnic barriers can actually be more effective than matching the backgrounds of the interviewer and interviewee.
>
> Rubin and Rubin 1995: 111.

Assumptions, created by the interviewer and interviewee's shared experiences, may impact on the quality of data collection, and participants might hold back from giving fulsome accounts, relying on the interviewer to draw on their own background rather than giving a full and explicit account. The methods literature, however, notes the importance of critical self-scrutiny that should be afforded by the researcher in his or her reflections of the research process (Byrne 2004):

> Far better to acknowledge that the researcher is part of the world which he/she is researching, that different factors will influence the interviewee, and to take account of these in the kinds of claims you might make on the basis of the data that is generated through this necessarily unpredictable and often shaky and perplexing process.
>
> Gray 2003: 72.

In a consumer attitude survey, Groves and Nancy Fultz (1985) analysed the effects of interviewer gender on response rates and found that female interviewers were more successful at getting responses than were male interviewers. Bernard (2000) and Seidman (1998) document a handful of studies which have similarly attributed different response effects to the gender of the researcher, but the overall impact of interviewers' characteristics are inconclusive (Williams and Heikes 1993; Bryman 2001). Reinharz and Chase (2001) cite

the work of Padfield and Procter (1996) which found no significant differences in women's attitudes in response to the interviewers' genders, even on sensitive topics such as feminism and abortion. In their telephone survey, Huddy *et al.* (1997) found that their younger respondents and those with less formal education were more susceptible to interviewer's gender, but the differences were not significant and were not repeated in a later survey. Catania *et al.* (1996) found that in allowing people to choose their interviewer's gender, women typically selected women, while men split relatively evenly. The study, however, was confined to examining a number of highly sensitive sexual topics, and the authors concluded that in general, their results did not support the proposition that women are more influenced than males by interviewer-gender differences.

In this study, the elite interviewees were primarily men, though women Welsh Assembly and MEP policymakers, and medical service providers – including two Deans and two senior consultants amongst others – were also interviewed. There were no identifiable differences among the responses of male and female elites. The nature of their occupational positions meant that they were generally used to being questioned (Ball 1994) whether by political journalists or (public and private) health system users.

The PRHO interview informants were initially all female. Concerns over the possible 'gendered' nature of the data led to a series of interviews with male doctors, thus balancing out the views to five female and four male interviewees. For reasons related to the junior doctors' lack of status compared with the elites, it was anticipated that responses may vary according to their respective genders. Like the elites, however, this was not the case. The length of every interview, based on a loosely standardised schedule of questions, took approximately an hour, with little variation in the types of responses elicited. This was most surprising as some lines of enquiry were quite sensitive, particularly relating to experiences of ill health resulting from working time. Other questions surrounding work-life balance were expected to be approached differently between the male and female informants, given the importance afforded within the general labour market to flexible working arrangements and part-time work to accommodate women's childbearing roles (chapter 3). Despite some of the different circumstances between the PRHOs, such as Dr C being married compared with the single status of her other junior doctor counterparts, and Dr G's 'flexible' training following a history of depression put side by side with the other PRHOs' general good health, the overall

process revealed a distinct similarity in the responses given by both male and female PRHO informants.

This supports the conclusions drawn from general research that the interviewer's gender can be minimal. It also enhanced my confidence in the reliability of the methods used. To further reinforce the applicability of this argument within the present study, one could refer to the literature which looks at the general heterogeneity of the medical profession and it's largely closed social culture within which attitudes and ideas are recycled between generations of doctors (chapter 4). Looking at the responses from this perspective explains the general commonality in outlooks. This is not to suggest that all PRHOs think alike, but the study found a set of common themes and priorities which linked this population in a particular way. It is possible that owing to the nature of the routine work associated with the profession, that the PRHOs simply applied their clinical 'bedside mannerisms' to the interview situation (Atkinson 1995). Like their everyday patients, I was concerned to extract a particular facet of their knowledge, that is, their knowledge and experience of work time conditions, rather than the patient's ordinary concern for clinical expertise. Room for emotional responses was limited in the social science interview as it presumably is in the clinical environment. Consistency, clarity and confidence in responding to my questions were applied as though the interview comprised an encounter between the doctors and their patients. As such, the interviewer's characteristics played a minimal role.

Postal Questionnaire Survey

The questionnaire survey was another element of the study, and had two main objectives. First, it aimed to gather basic information on the working patterns of PRHOs, and to provide a descriptive overview of attitudes on the regulation of working time. Second, it acted as a 'sift' through which a sample of PRHO interviewees could be obtained at a later stage of the study. The survey questionnaire was informed by the issues raised in the initial literature reviews and the concerns reflected in the research objectives:

> The aims and objectives of a social survey emerge from the theoretical concerns of an academic discipline as set out in the literature, from the concerns of policy makers or from the personal interests of the researcher.
>
> Bloch 2004: 164.

An identical set of questionnaire surveys was posted to two different cohorts of PRHOs practising under the direction of the Postgraduate Deanery in Wales: 267 surveys were sent to the 2004-05 cohort in April 2004, which was four months before the compulsory implementation of the EWTD. A year later, 256 questionnaires were posted to the 2005-06 cohort. The response rate for the first survey was 30% (80 questionnaires), and 23% (59 questionnaires) for the second. Although this figure may appear relatively low, low response rates are not unusual for postal questionnaires of this type. Nevertheless, caution should be taken in interpreting the data recorded by the survey in view of the low response rate. It is difficult to assess non-response bias, owing to the limited amount of demographic information collected (although the response rate for male and female doctors was similar), and to the lack of comparative data for the wider population of junior doctors. The response rate for male and female doctors was similar. The difficulties in assessing the actual non-response bias do reflect a limitation on the survey's findings. It is not possible to explore whether the non-responders would have responded differently on the issues raised by the regulation. However, it is reasonable to speculate that doctors who were particularly concerned about the issue of working time might have been more likely to return the survey. This may consequently have tilted the overall results towards expressing more concern about the EWTD. For example, the respondents supporting the EWTD referred to the need for regulation in order to limit the detrimental impact of working time on their personal health. Over 40% of respondents perceived that they had experienced some form of ill-health as a result of their working time. Having said this, a similar proportion of respondents (56%) argued against the EWTD as they saw it as curbing their potential earning capacity.

Overall, the survey did not identify a general strong opposition to the EWTD. In fact, 80% of the respondents were of the opinion that doctors should not be excluded from within the scope of the legislation. Chapter 8 discusses these findings in further detail, and illustrates the junior doctors' mixed reaction towards the EWTD depending on whether the respondents chose to talk about its perceived impact on health, work-life, salary, medical training and/or medical service. Chapter 6 reinforces this inconsistency by identifying a similar degree contradiction in the elite informants' responses that were elicited in the interviews. These findings typically show that while the survey respondents did include a mix of those who argued both for and against the Directive, it also consisted of a group of junior doctors who did not hold strong views either way, and who appeared seemingly unconcerned about the

issue of working time. This does not necessarily prove that the findings are more or less valid. There is no straightforward way of testing non-response bias in the absence of comparative samples against which the responses of this study can be compared. However, the survey findings do provide a basis upon which the author can make informed judgments about the perceived impacts of the EWTD. In light of the above comments, it is reasonable to argue that the findings were not skewed by a sample of junior doctors who felt particularly affected by the Directive. Thus, although the low response rate is unfortunate the author felt confident that it does not mean that the research findings are fundamentally flawed, although clearly the possibility of non-response bias should be taken into consideration when interpreting the results.

The self-reporting nature of the survey also poses certain questions about the reliability of the data gathered, particularly as there is no comparable research against which the responses can be verified. The subjective nature of the responses raises questions about the variability between respondents' individual responses, all of which undermines the ability to provide an authoritative measurement of the specific impact of the Directive's provisions. The findings therefore only provide a basis for informed speculation about the effects of the regulations' implementation.

The survey attempted to balance factual, opinion-based, closed and open-ended questions (a copy is included in the appendix), and was shaped by the aims and objectives of the study. Concerns over poor response rates influenced my decision to limit both the number of open-ended questions and the overall length of the questionnaire survey. In spite of the sample population, it also avoided medical jargon in order to retain simplicity and avoid potential confusion. The questionnaire was separated into five short sections. Following the request for general demographic data, section 2 of the questionnaire sought to gauge compliance with the legislation by enquiring about the respondents' average weekly hours. The third section explored PRHO attitudes towards the impact of working hours and health, given that this relationship was a key concern of the Directive. Subsequent questions in the section related to the willingness to take time off from work; work-life satisfaction; and the availability of flexible work arrangements in the NHS. Section 4 considered the effects of the EWTD on medical training and service. The questionnaire concluded with a section on regulation, examining the respondents' feelings about the EWTD, returning once again to themes of compliance. The overall layout therefore aimed to make the respondent feel as comfortable as

possible in answering the questionnaire, logically covering working hours, their effects, and the general impact of the Directive in their everyday work.

The initial reason for using two surveys was to compare the attitudes of PRHOs towards the regulation of their working time immediately preceding the date for the Directive's implementation with the experiences of PRHOs a year after the regulation's enforcement. It became apparent, however, that a strict before-and-after analysis was not possible. The validity of such an exercise was affected by the inconsistent implementation of the Directive between different NHS trusts, particularly after the unanticipated European case law. Nevertheless, the object of the two surveys was achieved, which was to provide a general understanding of the work attitudes and practices surrounding regulation. They substantially increased the amount of data, thus making quantitative analyses more credible, and afforded two opportunities to recruit a sample of PRHO interviewees.

At the time of each sweep of the survey, the PRHOs usually spent two six-month periods at different hospitals in Wales. The questionnaire surveys were posted to doctors' permanent home addresses mid-way through their two composites so as to allow them sufficient experience to properly evaluate the survey's questions. Posting the survey at an earlier date may have left the respondents with inadequate experience to provide a holistic impression of their PRHO year. Had the survey been posted later, then the response rates may have been jeopardised by the PRHOs' preoccupation with their final part of training and GMC registration. Under these conditions, it was doubted whether much priority would be afforded to the survey, which would reduce the response rates even further.

The questionnaire was sent with both a prepaid self-addressed envelope and a brief cover letter guaranteeing the informants' anonymity. A copy of the letters sent by the Junior Doctor Coordinator at the Welsh Assembly government and the Postgraduate Deanery in Wales endorsing the study were also enclosed to lend credence to the research. 'Reminder surveys' were sent to those respondents who had not replied within two weeks, reasserting the nature and aims of the survey. Caution was taken not to allow for an excessive time interval between the first survey and the reminder. A rapid follow-up would emphasise the importance attached to the study and, in terms of validity, it would minimise the potential for intervening events which could shape the respondents' answers. The choice of a postal rather than telephone or face-to-face questionnaires was largely a pragmatic decision. The postal option

was the most feasible and cost-effective in gathering data of a standardised nature from such a large cohort of respondents. Furthermore, finding a convenient time to carry out telephone or face-to-face questionnaires was too demanding, particularly given the PRHOs' working patterns. Access and exclusion were also considered important issues as not all respondents had listed telephone numbers, whereas they all had a postal address to which a questionnaire could be sent.

The reliability of the surveys was underscored by their identical questionnaires administered to the same target population on two separate occasions. Furthermore, the results from each one yielded few differences in the responses provided. The consistency of the data may have been further tested if the same respondents were surveyed twice, that is either twice during the same PRHO year, or by a follow-up study a year later during their senior house officer (SHO) training. The first of these ideas was dismissed given that the first of the two surveys would have to have been posted at an earlier stage of their PRHO year. I decided that the respondents may not have gained sufficient experience in this time to form adequate impressions on the regulation of their working time. The reliability of the second option encompassing a survey in both the PRHO and then the SHO year would have been equally contentious. Each year may raise training and service demands of a different nature, thus making the reliability of the data less consistent.

Diaries

To grasp an in-depth understanding of PRHOs' experiences inside the hospital environment and the impact on personal life, two junior doctors contemporaneously recorded their thoughts on a Dictaphone on two separate days at work. Having recruited them from the survey in very much the same way as the interviewees, the nature and aims of the research were explained to the participants, who were also provided with a list of loosely worded questions arranged thematically upon which they were required to comment (see appendix; the questions appeared in the same order as both the survey and interview schedule for the purposes of maintaining consistency and efficient coding). Owing to the impracticality of having to regularly refer to this list at work, the informants were asked to read the questions thoroughly before and after their shift. The detail of each entry was left for the informant to determine thereby reducing the effects of researcher bias. The contemporaneous nature of the diary overcame the problems of recalling events that were probed in both the surveys and

interviews, but there was no guarantee that the participants strictly adhered to the instructions given to them:

> Informants may deviate from instructions...by failing to record the events while they are fresh in their memories; the main strength of the diary approach is the avoidance of reliance on memory, but, if the informant does not keep the diary up-to-date, at least part of that strength is lost.
>
> Moser and Kalton 1971: 82.

One informant used her diary during a period of on-call whereas the other recorded her thoughts during a normal shift. The disadvantages of the method, however, became quite clear at an early stage. The extra work involved in carrying a device around the workplace recording contemporaneous thoughts and experiences deterred many from taking the method up. It was far more demanding than completing a short questionnaire and the problem was reflected in the poor participation. The method was intended to gather more information to compensate for the decision not to pursue ethnographic techniques but only two females came forward despite a generous financial incentive, which consequently limited its value in terms of extrapolating the data.

Access

Two approaches were taken to accessing the study's informants. These are discussed in turn, looking firstly at the way in which the survey sample was obtained; the second section then explains the issues surrounding the access to elites. The survey sampling frame comprised of two cohorts of PRHOs under the Postgraduate Deanery for Medical and Dental Education in Wales. Having undertaken part-time work at a Medical School for some time before and during the research, my senior manager, who had taken particular interest in the study, was able to provide me with the addresses of all PRHOs training in Wales through another internal source at the School. This is an example of 'convenience sampling' (Bryman 2001) – an opportunity which I was reluctant to turn down. Feldman *et al.* (2003) argue that accessing a sample can be largely attributable to an element of good fortune, which was the case for this study:

> Luck was also an important part of gaining access...luck that involved preparedness meeting opportunity...luck has this funny quality: You cannot make it happen, but it does not happen if you sit around and wait...[it] often involves meeting the right person, a person who can help open the doors that you need to go through.
>
> Feldman *et al.* 2003: 10.

By the time of the fieldwork, I had worked with this person for a period of three years, and had developed a high degree of trust. This was, at the time, also justified given that none of the respondents questioned my access to their personal information. As a matter of professional courtesy, the process involved assurances of confidentiality and that the information, in addition to it being guaranteed for proper research use, would subsequently be destroyed. Had accessing the survey population proven difficult, a second strategy was to rely on the cooperation of both the Postgraduate Deanery and the National Assembly for Wales. Both were made aware of the research from an early stage, and had endorsed the study by way of written letters. These were photocopied and enclosed with each questionnaire survey to elevate the credibility of the work being undertaken.

Studies on elite interviewing advise researchers to draw attention to their institutional affiliation, use personal connections where possible, and seek to obtain an influential "sponsor" whose endorsement of the project will ensure the cooperation of the rest of the group (Welch *et al.* 2002). In this study, the research was explicitly endorsed by both the Junior Doctor Coordinator at the National Assembly of Wales and by the Postgraduate Deanery in Wales. These were expressly acknowledged in the covering letters addressed to the elites, and explained the nature of the research, the importance of that particular informant's input to the study with an indication of the sorts of questions that would be asked. This also provided them with time to consider and to prepare answers (Lilleker 2003). A list of high-profile figures emerged as the process of interviewing progressed and, to elevate the credibility of the study, some of these names were referred to in the later letters sent to the elites. In addition to the study's 'sponsors', part of the process of accessing elites involved using other sampling techniques which went beyond the personal networks established at the Medical school. Snowballing, as a means of both identifying and locating key informants, was used by asking other interviewees for their recommendations on the most appropriate figures to interview in respect of a particular aspect of the study's investigations (Undheim 2003).

Compared to general informants, access to elites is regarded as particularly difficult because by their nature they "establish barriers that set their members apart from the rest of society" (Hertz and Imber 1993: 3). Locating them was not a significant problem, and the majority could be contacted using recognised channels, such as e-mail or by the more conventional written methods. Increased mobility, however, has meant that people are difficult to find in their offices (Undheim 2003). A greater difficulty arises when one seeks to interview those who are no longer active in public life. This was illustrated in the problems of locating an ex-ECJ Judge who presided for the UK in the case of SIMAP. Having explored the ramifications of the judicial ruling from the perspectives of medical service providers and policymakers, it was felt necessary to balance these views with those of the judiciary. The route to locating the judge involved quite some research using European electronic sources, legal literature and general internet searches. The process can therefore be far more time-consuming and expensive than making contact with non-elites (Undheim 2003). Meeting the policymakers in Brussels – the Welsh Local Government Authority, the National Assembly for Wales' EU delegates, and an EC Commissioner – followed by interviews in Luxembourg with the Advocate General of the ECJ, and in both London and North Wales with BMA representatives – were costly.

The limited time for which many of the elites reserved for the interviews more often than not meant that the meetings would be held at a place convenient to them. In some instances, the restrictive times dictated the pace of the interview, the length of the schedule and the overall quality of data gathered. Although an hour's interview was requested in the letters, some declared at the meeting that they could only manage half an hour or less as a result of their busy schedules. These experiences echo the commentaries by Puwar (1997) in her interviews with women MPs. By attempting to accommodate the informant's time commitment as far as possible, the elite interviews at time involved quickly prioritizing questions and deciding what to ask and what to leave out at the same time as the questions were being asked:

> The exchanges...were rather more hurried than we would have wished. We also edited the schedule as the interview proceeded, in order to give priority to what we thought were the key questions.
>
> Fitz and Halpin 1994: 47.

This is a clear illustration of the imbalance in authority between the interviewer and interviewee, and reflects the broader difficulties in analysing the data provided by the elites. This concern forms a core theme of the next section on data analysis.

Analysis of the qualitative and quantitative data

Discussions on accessing the elite interviewees demonstrate how studies incorporating such samples "are irrevocably immersed in issues of power, domination, and authority" (Undheim 2003: 105). This contrasts with the qualitative research tradition that is frequently associated with studies of marginal or powerless groups, in which it is generally assumed that researcher is the one with the higher status (Taylor and Bogdan 1998). Studies on elite interviewing, however, are almost unanimous in arguing that the power balance is likely to favour the informants over the researcher (Welch *et al.* 2002). This tendency was particularly evident in the current study as the elites' accounts comprised certain themes such as political and professional policy that were beyond my knowledge and experience. Several of them described how some clinical procedures and other technical aspects of medical training were adversely affected by the EWTD. This issue became particularly problematic in the first set of interviews. I became immediately aware that my knowledge of the politico-clinical aspects of some debates in this field derived mainly from documentary-based research and analyses of official and unofficial reports. My consequent ability to assess critically the interview data was a concern of which I was very aware, a concern encapsulated in the following extract:

> It's easy to make oneself believe that one account is more accurate than the other because a subject was more knowledgeable.
>
> Berry 2002: 680.

The challenge in this study was therefore to be as objective as possible in evaluating critically the accounts provided by the informants. The literature refers to interviews as co-constructed narratives, which are constructed both by the interviewer and interviewee (Yates 2004). Looking at the issue from this point of view, I did not interpret the narratives as straightforward factual accounts, but rather of versions of perceptions that could be compared against other sources of data, particularly the official and unofficial documentary sources that were used (the findings of which are reported in the next three chapters) and the primary data gathered in the surveys. I also attempted to 'check' the various accounts by cross-referencing

the data gathered in the various elite interviews (Phillips 1998). This illustrates the further use of triangulating data to corroborate the data elicited from different sources (Bryman 1992).

The survey data was subsequently checked and systematically entered into computer files using the Statistical Package for the Social Sciences (SPSS). Analysis of the data was not overly problematic as the survey had been designed with this feature in mind. The majority of structured questions made it easier to conduct comparisons and to allow for some generalisations. The intention in carrying out the survey was only to carry out one large descriptive analysis; the data gathered from the semi-structured interviews would provide the study with a more in-depth understanding. In this sense, both methods complemented each other.

The interview data was analysed in a number of stages (Ritchie and Lewis 2003). The first involved the transcription process. The decision not to delegate this task of transcribing to somebody else was partly influenced by the expense of doing so, particularly given that forty-four informants were interviewed. More importantly, it provided an opportunity for me to revisit the data and to listen again in detail to every interview. This practice familiarised me very closely with the data, and started the process of distilling key themes and categories from the data. The second stage of analysis involved careful reading through each transcript, highlighting the main themes and sub-themes that were emerging from them, and annotating the hard copies accordingly. Thirdly, a framework of thematic grids was developed onto which the summary information and references to key quotes for each interview were transferred (May 2001). This process facilitated a comparative analysis between the responses given by different informants. The following headings were used:

- Working Hours
    - Experience (Actual/Prescribed)
- Impact
    - Health and safety, and work-life
    - Medical training
    - Service
    - Staffing
    - Re-defining roles
    - Implementation strategies
- Regulation
    - EC legislature
    - UK state

    - Management
    - Self-regulation
- Misc

These headings reflect the concerns raised in the study's aims and objectives. As such, the findings served to confirm or falsify existing research, whilst encapsulating all themes relevant to the topic of work-time regulation under one broad project. The fourth and final part of the analysis involved reviewing these grids to explore the major patterns and themes that were emerging from the data. These were used as the basis for developing the main findings chapters.

Ethical Considerations

A central objective of any social research is to acquire and disseminate reliable information in ways that cause no harm to those being studied (Rubin and Rubin 1995). Ethical issues are particularly likely to arise using qualitative research methods because, "while all social research intrudes to some extent into people's lives, qualitative research often intrudes more" (Punch 2005: 276). Not only is the integrity of the researcher put under scrutiny, but attaining high ethical standards is imperative to preserve the professional research community:

> Sociological research is a valuable activity and contributes to the well-being of society. Members should strive to maintain the integrity of sociological inquiry as a discipline...
>
> British Sociological Association (BSA) 2002: pt 5.

To varying degrees, the interviews required a relationship of trust between the researcher and the researched (Yates 2004). This was achieved by addressing issues of informed consent and confidentiality at the study's outset. These are discussed in turn.

Informed consent

Informed consent was necessary particularly in relation to the study's attempts to explore the informant's personal lives and health issues. Each interview commenced with a verbal rationale for that which was being studied in order to give the informants a sense of participation in the research process. This could have been achieved by obtaining written consent, but over-formalising the situation did not correspond with the aim of achieving a

relaxed, informal rapport. A brief rationale containing the aims, objectives and methods of gathering data was therefore distributed to each informant accompanying their postal questionnaires and subsequent letters requesting interviews. It was felt that this information was sufficient to provide the informants with the details and purpose of the study, the use of the data, and their role and contribution. It explicitly noted the confidential nature of their comments, and my respect for their anonymity.

At different points in the interview, the informants were reminded that they were not obliged to answer specific questions, particularly in relation to those focusing on health. Two doctors spoke in length about their history of mental illness and depression without any apparent reservation. This may be attributable to their everyday dealings with poor health, and professional obligations to be honest and direct. It was a common aspect associated with all the PRHO interviews, and realised more so in hindsight than at the time. There was no conscious intention within the interview situations of taking advantage of or taking for granted the frank and voluntary exchange of information provided by the PRHOs.

Anonymity and Confidentiality

The interviewees were assured that no information which could be used to identify them would be made available without their consent. They were also informed as to who could potentially read the findings in line with the relevant code of ethical issues:

> The anonymity and privacy of those who participate in the research process should be respected
>
> BSA 2002: pt 34.

In quantitative research it is relatively easy to anonymise records and to report findings in a way that restricts the identification of individual informants (Bryman 2001). For this study, each survey respondent was identified by a random 3-figure digit. The PRHO interviewees have been referred to as Drs A-I, whereas the elites are classified by their occupational position. The latter, however, are more identifiable as a result of their public roles, and will be known to some of their fellow informants because of the 'snowball sampling' procedure which was adopted. Nevertheless, these interviewees showed little sign of apprehension of the prospect of being identified. Moreover, attempts were made as far as possible to anonymise their contribution by referring to them in the findings in their occupational and/or

organisational capacity, such as "staffing manager", "EC Commissioner", and so on. Those interviewees who were named gave their explicit permission for this to take place.

Conclusion

The research process has embraced a mix of quantitative and qualitative methods to address the research objectives posed by the study. The emphasis on triangulating data has exploited the strengths and minimised the inadequacies associated with each individual method. These discussions have set the scene for the next three chapters which provide the necessary context, upon which the later chapters will report the findings. In turn, they set out an historical review of general employment relations in the UK, before focusing more specifically on the regulation of the medical profession. The regulation of doctors' working time is then discussed, thus giving the reader an understanding of the broader issues which are relevant to this study's aims and objectives in addition to the more specific debates that are voiced in the current climate.

Chapter 3

Regulating working time in the UK

Introduction

This chapter summarises the history of the regulation of working time in the UK. It addresses the study's overarching aim of analysing the process and impact of legal regulation on employment conditions in the UK labour market, with particular reference to the European Working Time Directive (EWTD). The chapter commences by briefly reviewing the EWTD, which forms the focal point of this study. It then concentrates on the longstanding campaigns by both trade unions and workers in Britain to reduce hours of work through collective bargaining, before mapping out the EWTD's turbulent passage. These discussions highlight the tensions arising from the evolution of state regulation at both European and UK levels on an issue of labour conditions, which has been conventionally determined by employers and employees and, particularly during the last two centuries, trade unions.

The chapter concludes with an examination of the main impact of the Directive on both working conditions and employment relations in the UK. This part addresses the study's objectives of examining the different ways in which the regulation has been implemented and enforced in practice. The focus is on the labour market as a whole rather than looking specifically at the medical profession. It is important to show that tensions about centralised statutory control exist outside this study's primary focus on the medical profession. The EWTD's origin, nature, opportunity for trade union participation and overall impact on labour market regulation underscore the differences and similarities between the Conservative and New Labour governments' policies, while contextualising the general situation within which the doctors are currently regulated.

The European Working Time Directive

European Community directives are "binding as to the result to be achieved upon each Member to which it is addressed, but leave the national authorities the choice of forms and methods" (Art. 249 EC Treaty). In permitting the EC states to implement the measure in a form of their choice, it facilitates the harmonisation of national and EC law in a flexible manner and within a stipulated timeframe. The national authorities have a duty to interpret

EC measures in accordance with the spirit under which they were passed. This duty is more commonly referred to as the 'mischief rule',[1] and was explicitly applied in the UK case of Barber v RJB [1999] where the High Court acknowledged that the provisions of the EWTD imposed an explicit contractual duty which should be recognised between all employers and their employees. The nature of European law also means that all pre-existing national legislation must also be interpreted in conformity with the stated objectives of the more recently enacted EC measure.[2] For the UK, then, the courts must construe the Directive with existing legislation such as the Health and Safety at Work Act 1974. Any conflict arising between Community and national law will result in the former prevailing.[3]

The EWTD comprises a number of provisions which aim to regulate working time across the European Community. It imposes maximum weekly working time of 48 hours which is generally averaged over 17 weeks. The regulation also covers minimum and weekly rest-periods, annual paid holidays, and restrictions on night work. The philosophies underpinning the legislation relate to the EC Treaty Article under which it was passed, namely to protect the health and safety of workers. The Directive was adopted by Member States on 23 November 1996, but the UK delayed its implementation following the then Conservative government's unsuccessful appeal to the European Court of Justice (ECJ) to have the Directive annulled. The task of implementing it therefore fell to New Labour which, following the General Election in May 1997, laid the Working Time Regulations before Parliament on 31 July 1998; they subsequently came into force on 1 October 1998. The Regulations similarly correspond with the EWTD's stated health and safety intentions, but also encompass a broader aim to address work-life balance:

> To achieve benefits for workers including a better balance between work and family life, with commensurate improvements to Health and Safety.
>
> DTI 2002*b*: Section 6.

---

[1] Colson v Land Nordrhein-Westfalen Case 14/83 [1984] ECR 1981.

[2] Marleasing SA v La Comercial Internacional de Alimentacion SA (case C-106/89) [1990] ECR I-4135. This was applied by the House of Lords in Webb v EMO Air Cargo (UK) Ltd [1993] 1 WLR 49.

[3] Costa v ENEL Case 6/64 [1964] ECR 585.

This is the first legislation of its kind governing working time in the UK. The Directive permits individual workers to agree with their employers to derogate from the maximum weekly limit provided that the agreement is recorded in writing, and is available for inspection by the Health and Safety Executive (HSE) officer or any other authority responsible for the Regulations' enforcement. This agreement is commonly referred to as the 'opt out' and is contained in Article 18(1)(b)(i) of the EWTD. The task of enforcing the Regulations is split between different authorities: the weekly working time and night work limits, health assessments and record keeping are enforced by the HSE, local authority environmental health departments, and some sector-specific regulatory bodies. The entitlements to rest and leave are enforced by the individual worker through employment tribunals.

Subsequent amendments to the Directive have brought junior doctors and some of the other previously excluded sectors within its ambit. The ECJ has also had the opportunity to provide essential definitions on what constitutes working time for the purpose of the Directive. Nonetheless, in order to understand how the Directive has been embraced in the UK, it is necessary to analyse the political debates about working time in the UK.

The historical regulation of working time in the UK

Working time has long been subject to clashes between employers and unions. The historical campaign for reducing time spent at the workplace has been the focus of union struggle, resulting in a sporadic statutory patchwork of regulation (Bishop and Mayer 1995). The campaign to reduce time spent at the workplace in the UK spans over two hundred years, during which trade unions have successfully lobbied for reductions from about 90 hours per week in 1750, to around 40 today. Hunt (1981) and Evans and Palmer (1985) document attempts by Sheffield silversmiths and petitions by a union of Journeymen Taylors in London to reduce their working hours in 1680 and 1720. These accounts trace this contested history.

Poor working conditions – overstrain, exhaustion, excessive work amounts, and inadequate rest – brought about during the industrial revolution (McIvor 1987) led the unions to mount a general campaign during the 1830s and 1840s for a standardised 10-hour working day; a 'Nine Hours' Movement' followed between the 1850s and 1870s. Their efforts initially culminated in legislative protection for factory workers, and Parliament subsequently passed

the Factory Acts of 1850 and 1853 which extended the provisions to the cotton and woollen mills in the 1860s. Further legislation resulted in 1872, 1886 and 1893, implementing maximum limits on the hours of work for young coal miners, shop assistants and railwaymen, respectively. Governments were also responsible in 1889 for establishing a 48-hour week in dockyards, workshops and arsenals in line with a campaign for an eight-hour day. By the end of the 1890s, more than five hundred workplaces across the country had adopted the 48-hour week (Evans and Palmer 1985).

Conditions at work, coupled with their adverse impact on health and educational development, underpinned the state's intervention (Dawson *et al.* 1988). At the time, political survival following the expansions of the franchise between 1884 and 1928 ultimately meant that governments were under pressure to respond to its growing working-class electorate and to address their concerns over workplace conditions. This was balanced against the industrialists' opposition to reform, who feared the impact of a regulated market impinging on productivity, profits and national competitiveness (McIvor 1987; Hart 1987). As a result, there was no attempt to regulate the labour market as a whole; in fact where legislation was enacted, it was largely sector-specific – factories, mines and mills for example – and it targeted those workers who were perceived by the state as the vulnerable and exploited by the labour market. These measures were invariably restricted to women and children.

Child exploitation was addressed by the Health and Morals of Apprentices Act 1802, which limited apprentices to 12 hours per day, though like other laws it was only partially enforced. Consequently, other legislation followed in 1819, 1833 and 1844 to improve the policing mechanisms, and to develop in piecemeal forms some blanket exclusions on child mistreatment at work. The 1833 and 1844 legislation applied predominantly to the textiles industry (and was extended to mining in 1842 and during the 1860s) and at first, limited the employment of workers between the ages of 13 and 18 to 10 hours per day, and then later banned female workers and males under 10 years from working in coal mines. The Factory Act of 1874 introduced a 10-hour day for women and young workers (in addition to reducing the overall working hours in the textiles industry to 56 ½ per week by increasing meal breaks to two hours and shortening Saturday working by an hour). The intervention was accompanied by a change of attitude and employment patterns, together with a degree of compulsory education (made mandatory by the Education Acts of 1870, 1876 and 1880). Statutory limits on the working hours of girls and women to 'protect' them from the

harshness of factory life also served to sanction their dependence on men in order to protect the family, the institution responsible for the reproduction of labour-power (Arrowsmith 2002).

Campaigns to reduce working time continued into the twentieth century, particularly among the munitions workers in 1914-15 who worked, at times, up to 80 hours per week. In piecemeal fashion, the government, during the First World War, began to address such conditions by abolishing Sunday working, introducing systematic rest pauses, and capping the working hours of women and juveniles at 60, and 67 for men. Legislation was passed in 1919 reforming its 1908 equivalent to reduce the miners' working hours from an eight-hour to a seven-hour day. This represented the first legal restriction of adult male workers' hours following trade union campaigns within the industry. Various strikes and stoppages led to similar working time reductions in engineering, railway workers, printing, building, dock workers and the cotton industry.

The Factory Act of 1937 repealed its earlier counterpart passed in 1901 to impose a maximum 48-hour working week with a host of other provisions curtailing overtime, introducing rest breaks and medical inspections, and to make the provision of seating, washing and cloakrooms compulsory in all factories. This legal framework was consolidated in the Factories Act 1961, which was enforced primarily by the factories inspectorate, and the Health and Safety Executive after 1974. The Act also limited spells of continuous work, and protected certain holidays for women and young workers, such as bank holidays and Christmas day. The Shops Act 1950 consolidated similar measures applicable to the retail industry, by limiting working hours generally and on Sundays.

Having agreed to suspend action during the Second World War, the unions' promotion of a five-day/44-hour week followed soon after, with a similar campaign for a 40-hour week in the 1960s, spurred on by the printers' industrial action in 1959. The government passed a plethora of legislative reforms but these were sector-specific and continued to limit the hours of specific workers, mainly women and young people. Further attempts to achieve a 35-hour basic week in the 1970s followed, particularly among painters, electricians and tobacco workers (for further detail, see Evans and Palmer 1985) and, despite the high levels of inflation and subsequent unemployment in the wake of the 1974 oil crisis, the campaign to reduce working hours did not lose momentum. The TUC and the European Trade Union

Confederation (ETUC) pressed for further reforms, drawing together policies that dealt with, among other issues, a reduction in the basic working week to 35 hours. At the time of the Conservative Party's election victory in May 1979, employers, particularly in the engineering industry, were pressured by industrial action and threats of further disputes, and had initiated concessions that entailed a phased reduction in working time to 39 hours per week.

Set against a backdrop of recession, international and European competition, working time was a focus of successive Conservative governments in the 1980s and 1990s "deregulatory zeal" (Fitzpatrick 1997: 135). The Wages Act 1986 restricted the power of Wage Councils. Among other functions, Wage Councils were established to set minimum levels of remuneration, maximum working hours and paid holidays in specific industries (notably agriculture, clothing and textiles, retail, food, hotels and catering) where collective bargaining mechanisms did not exist (Dickens *et al.* 1999). Twenty-five Wage Councils were abolished in 1993 by the Trade Union Reform and Employment Rights Act by repealing Part II of the Wages Act (the Agricultural Wages Board was not abolished (Brown *et al.* 1997), and continues to set minimum wages for agricultural workers (DEFRA 2007)). The UK was the only Member State of the EU to have dismantled its general minimum wage setting machinery, however New Labour's introduction of a national minimum wage with effect from April 1999 brought the UK back into line with other EU Members (see below).

The Sex Discrimination Act 1986 repealed the existing restrictions on hours and overtime imposed on women workers, and the Employment Act 1989 removed the restrictions on the working hours of young people below the age of 18. The Deregulation and Contracting Out Act 1994 repealed the statutory regulation of shop workers' hours and the prohibition of Sunday working by betting workers, while the Sunday Trading Act 1994 repealed the general provisions previously in place limiting opening hours. Other statutory repeal included the provisions governing the number of hours spent underground by mineworkers, and night work by bakery workers. At the same time, legislation was passed to curtail the powers and authority of trade unions and shop stewards, consequently leading to the decline and decentralisation of collective bargaining arrangements. Such machinery had been fundamental to the organisation of the working class and the development of labour solidarity which had secured, at various times, the reductions in working time (Arrowsmith 2002).

The judiciary, at the same time, exercised its longstanding tradition of refusing to intervene with the fundamental terms contained in the employment contract that governed the employer-employee relationship, even if they were heavily weighted in favour of the former. The case of Tucker v British Leyland Motor Co. Ltd (1978) held that the worker was not entitled to any general restriction on weekly working hours; such conditions were for the individual parties to negotiate. The ruling followed previous decisions that endorsed the conventional voluntarist principles of the master and his servant (McMullen *et al.* 2001; Ewing 1996). In the case of NCB v Galley [1958], for example, an employer was held to have legitimately requested his employee to work eleven shifts on consecutive days and to subsequently dismiss the employee after he refused to work a twelfth shift, even though the worker's refusal was based on grounds of exhaustion and poor health. In practice therefore, the traditional freedom between the employer and employee to agree on the terms of their relationship often left the latter, as the weaker bargaining party, with insufficient protection (Napier 1991).

The emerging politico-legal context, drawing upon an historical legislative patchwork, resulted in the absence of a general regulation of working time in the UK labour market. The EWTD therefore represented a conspicuous attempt at introducing a concept foreign, in both territorial and ideological terms, to Britain's employment regime. The next section looks at the tensions between Europe and the UK in the former's attempts at regulating working time across the EU by way of supranational legislation and non-statutory controls. In so doing, it provides an understanding of the reasons underlying the state's attitude towards workplace regulation, and explains the conceptual grounds that have shaped the Directive's ultimate form in Britain.

Britain and the European Working Time Directive

Given Britain's then deregulatory policy, it comes as no surprise that the EWTD was generally opposed by the Conservative governments. As Secretary of State for Employment, Michael Howard, encapsulated the argument for challenging the Directive in reply to a Parliamentary question on the Directive:

> British industry is virtually unanimous in its opposition to the proposals the directive would be a needless strain to our competitiveness, and a threat to jobs and earnings.

Hansard 1991-1992 Col. 536.

Resistance to the EWTD was based upon orthodox economic theory that rigidly controlling the market by such measures ultimately damages competitiveness (Adnett and Hardy 2001).

Opposition to the EWTD was consistent with the Conservative government's attitude towards a host of similar proposals put forward by the EC. Having vetoed a 1983 recommendation on the reduction and reorganisation of working time following a replica Resolution in 1979, the UK government believed that national rather than supranational authorities were better equipped to tackle employment relations (Hantrais 2000). Its policy was reflected in the decision to exclude Britain from the Community Charter of the Fundamental Social Rights of the Worker, more commonly known as the Social Charter. The latter drew its inspiration from the International Labour Organisation (ILO), a body that promotes certain standards and freedoms associated with work, including the right to work, to just conditions of work, fair remuneration, and to organise and to bargain collectively. Britain had been criticised for persistently breaching ILO standards and other international agreements, such as the Minimum Wage-Fixing Convention 1928, the Freedom of Association and Protection of the Right to Organise 1948, and the Right to Organise and Collective Bargaining 1949 (Ewing 1996). Among the Social Chapter's proposed measures, Articles 7 and 19 specifically related to the improvement of working conditions:

> The completion of the internal market must lead to an improvement in the living and working conditions of workers in the European Community. This process must result from an approximation of these conditions while the improvement is being maintained, as regards in particular the duration and organisation of working time and forms of employment other than open-ended contracts, such as fixed term contracts, part-time working, temporary work and seasonal work.

Article 8 of the Charter explicitly acknowledged the need to regulate working time:

> Every worker of the European Community shall have a right to a weekly rest period and to annual paid leave, the duration of which must be progressively harmonised in accordance with national practices.

Britain's consistent policy of opposing such social and workplace regulation meant that a "twin track" Europe rapidly emerged, with the UK "occupying the slow lane of social policy reform, at odds with a more socially orientated Commission and European Parliament" (McMullen *et al.* 2001: 3; Pollack 2003; Bishop and Mayer 1995). The UK's exclusion from the Social Charter was similarly reflected in its decision not to participate in the 1992 Maastricht summit and the Protocol on Social Policy. In its absence, however, the European Council was empowered, if it attained a qualified majority vote, to adopt directives and other measures covered by Social Action Programmes (SAP); among other areas, SAPs regulate issues involving health and safety and general working conditions. This authorised the EC institutions to proceed with the Charter and to make decisions without taking into account the oppositional views held by the UK government.

The UK government did, on the other hand, accepted the Single European Act 1986 and its goal of free trade within an integrated internal market (McMullen *et al.* 2001). However, the Act also inserted a new Article 118a into the EC Treaty, which required Member States to pay particular attention to encouraging improvements, especially in the working environment, regarding the health and safety of workers. Furthermore, the Article altered the voting procedures for measures introduced within its ambit from the requirement for unanimous decisions to a qualified majority. This was to accelerate the decision-making processes (whereas the passage of measures had previously been restricted by their need to obtain unanimous agreement), with the overarching aim of achieving the single market by the early 1990s (Bishop and Mayer 1995). A prominent example of one such measure passed under the modified Article was the 1989 Framework Health and Safety Directive 89/391/EEC. Introduced to improve the safety and health of workers, it defines the employer's responsibility to provide competent protective and preventive services; information concerning safety risks and protective and preventive measures; and consultation, participation and training of workers, including health surveillance (Nicholson 2002). The Directive also provides for a broad definition of health and safety reflecting that of the World Health Organisation (WHO):

> Health is a state of complete physical, mental and social well-being and does not constitute only in the absence of disease or infirmity.
>
> WHO 1948.

It was against this backdrop that the EWTD's proposals were adopted in 1993 (Adnett and Hardy 2001). The premise of the legislation is based on the health and safety of the European workforce. The broad WHO definition of health and safety was applied to link long working hours and the workers' adverse physical, mental and social well-being (Craig 1998). Concerns over workers' health and safety were drawn from significant empirical research which had investigated the relationship between work and health (Kodz *et al.* 2003). Stress and fatigue, for example, represent some of the most common work-related health problems among general workplaces in the EU (Merllie and Paoli 2000).

General studies have associated long working hours with various physical symptoms, including cardiovascular disorders (Buell and Breslow 1960), chronic headaches and bowel problems (Chartered Institute of Personnel and Development 2001). Other research also correlates long periods of time spent at work with stress and other psychological problems such as anxiety, frustration, mood symptoms and tension (Beswick and White 2003; Kirkaldy *et al.* 2002; TUC 2000; Baldwin *et al.* 1997a; McKee and Black 1992; Barton *et al.* 1995; Wilkinson *et al.* 1975; McManus *et al.* 1977). In the UK, 72 per cent of workers claim they are highly stressed (TUC 2002). The European Commission has also underscored the benefits that the general public may derive from workers' working-time regulation, particularly with regard to transport activities and doctors in training, where fatigue brought on by excessive hours of work may constitute a direct risk to the welfare and safety of others (COM 1997).

The straightforward hours/health relationship is contested by some commentators (for example, Trimpop *et al.* 2000; Spurgeon *et al.* 1997; Baldwin *et al.* 1997*a*; 1997*b*; Cooper 1996; Harrington 1994). Craig (1998) argues that there is little correlation between long working hours and poor health. For this reason, he argues that the 1998 Working Time Regulations will not significantly improve the welfare of the workforce as intended by the Directive. This view was reflected in the UK's initial rejection of the regulation, and was encapsulated in a reply by the then Prime Minister, John Major, to an oral question in the House of Commons:

> The Working Time Directive cannot make any significant contribution to health and safety...It is precisely because of legislation like that and stupidities like that, that the European Union is becoming uncompetitive
>
> *Hansard (HC)* col. 782, 12 March 1996.

Various studies echo the concern that long working hours alone do not affect health. They typically adopt a multifactorial approach which considers the impact of other work conditions on health in addition to working time (Earnshaw and Cooper 1996; Bussing 1996; McKee and Black 1992; Cooper at al. 1989; Butterfield 1988; Scheiber 1987; Firth-Cozens 1987).

Nevertheless, with the legal basis for the Directive established, the modified voting procedures contained within Article 118a (as inserted by the Single European Act) meant that the UK's Conservative government was bound by a qualified majority decision; it could not, as had long been the case, utilise its power of veto to prevent the passage of the legislation. Its response was to bring a case to the ECJ, attempting to annul the EWTD on the grounds relating to the legal basis upon which the measure was passed (UK v Council of the European Union [1997]). The UK also claimed that the Directive did not respect the principles of the subsidiarity and proportionality, and that the European Council had misused its powers in passing the legislation. The ECJ rejected the thrust of the UK's arguments. In spite of the ruling and Britain's longstanding legal obligations to recognise the supremacy of EC law, the Conservative government continued to resist the Directive (DTI 1996).

The ECJ case and the Conservative's persisting opposition meant that the Directive was not implemented on time. Britain was not alone, however, in its failure to meet the deadline for transposing the EWTD into national law. Ireland, France, Greece, Italy, Luxembourg and Portugal also implemented the Directive after the 23 November 1993. Owing to the Conservative's "fanatical opposition" to the EC legislation (Prondzynski 1994: 92), Northern Ireland faced a judicial hearing which consequently found the UK to be in serious breach of Community law (R v Attorney General for Northern Ireland, ex parte Burns [1999]). Both the outgoing Conservative and the incoming New Labour governments therefore risked incurring liability for any harm resulting to individuals as a result of non-implementation.

It was left for the newly elected Labour government to transpose the EWTD into national law, and it did so by the Working Time Regulations 1998 which came into force on 1 October of that year. During the stages of negotiating the Directive's provisions, the Conservatives adopted a twin-track approach; the first opposed the legislation for its perceived impact on business interests. The Conservative's deregulatory policies were conceptually and operationally incompatible with a rigid legal framework; these advocates

argued that the regulation of working hours must be a matter solely for employers and employees to determine (DTI 1996: para. 1.6). The second outlook was more conciliatory, noting that the UK might be able to accommodate the Directive providing that its concerns, including voluntary opt-outs from the 48-hour week, excluded sectors, and other derogations, were addressed (Pollack 2003). These negotiations successfully secured a number of concessions to the British position. New Labour took full advantage of the derogations, thus replicating the conciliatory approach adopted by a proportion of their forerunners' members:

> By simply replicating the terms used in the directive the coverage of implementing legislation will be minimised so far is consistent with proper legislation.
>
> DTI 1996: Para. 3.5.

While the maximum weekly working time therefore rests at 48 hours, a significant proportion of the labour market was (and a lesser amount remains) exempt from the regulation. The 48-hour restriction is also generously averaged over a period of 17 weeks.

Impact

The EWTD provides a legal framework in an area of employment law where, as Fajertag's (1998) survey shows, most Member States already had national working-time legislation that was more restrictive than the Directive. The UK, on the other hand, had no statutory restrictions on working time, and its decentralised arrangements surrounding negotiations over working hours had resulted in an uneven pattern across different regions and sectors of the labour market (Bishop 2004; Kodz *et al.* 2003). The differences between the UK and other Member States therefore suggest that the former had to adapt to the regulatory systems far more substantially than other European states (Bishop 2004; Pollack 2003).

The average collectively-agreed weekly working time in the EU is 38.7 hours, with the highest working hours being experienced in retail (38.9) followed by doctors in public hospitals (38.8) (Eurofound 2007). The findings have remained stable since 2005, but the UK is the only Member State wherein the number of weekly hours has increased over the past decade (EIRO 2004a); its (full-time) workers' average number of actual weekly hours of work is 40.7, this being the ninth highest figure from a total of 27 Member States. The number of workers in the UK working in excess of 48 hours stands at nearly four million (TUC 2002). Working hours vary across the regions: London represents the highest

proportion of workers experiencing 48 or more hours a week (19%), whereas Wales and the North West clock the fewest hours over 48 per week (13%) (TUC 2001). Males disproportionately experience the longest hours in the UK (Bishop 2004; Amicus 2003).

A host of empirical research has assessed different facets of the EWTD in the UK. This section of the chapter is concerned with the impact of the regulation in light of its historical absence of working-time statutory controls and long working hours. It firstly looks at the legislation's effect on working conditions, and then focuses on its impact on labour relations. These discussions consider the debates focused at the level of the general labour market. The extensive debates within the medical profession and National Health Service surrounding the subsequent definition by the ECJ of what constitutes working time are reserved for chapter 5.

Working Conditions

The first point to note is that the EWTD does not cover the working conditions of all workers in the labour market. Owing to a number of operational difficulties, a total of 5.6 million workers were initially excluded from the provisions of the 1998 Directive (EIRO 1999). They comprised those in sea fishing and other work at sea, and of those in the road, rail, sea, air and inland waterways transport sectors, in addition to doctors in training. New Labour therefore implemented the negotiations specifically headed by the Conservative government almost six years earlier, retaining the minimalist features of the regulation.

Having launched a White Paper (COM 1997), the EC has now adopted new specific regulations bringing the excluded sectors within the ambit of the EWTD. They include the Road Transport Directive, the Aviation Directive and the EC Seafarers' Directive, with the latter being transposed into UK law by the Merchant Shipping (Hours of Work) Regulations 2002. Of these, the main constituent is the EC Horizontal Amending Directive 2003 (HAD), under which the working time of doctors in training is regulated. This has been implemented in Britain by the Working Time (Amendment) Regulations 2003. The HAD provides for an average 48-hour weekly working limit for doctors in training which is to be phased in over a period ending on 31 July 2009. The interim periods impose a 58-hour week and a 56-hour week in the Augusts of 2004 and 2007, respectively.

Some categories of workers remain exempt from the EWTD. They include the self-employed and domestic servants in private households, and those whose duration of working time is not

measured or predetermined. The latter typically involve managing executives and others with autonomous decision-taking powers, family workers and workers officiating at religious ceremonies. Workers under 18 years of age have special provisions under the Directive concerning the Protection of Young People at Work.

The most commonly voiced debates surrounding the general implementation and impact of the EWTD in the UK involve the workers' opportunity to voluntarily opt out of the legislation (Adnett and Hardy 2001). The Directive permits individual workers to agree with their employers to work over and above the maximum weekly limit provided that the agreement is recorded in writing and is available for inspection by the relevant enforcement authorities. This agreement is generally referred to as the 'opt out' and is contained in Article 18(1)(b)(i) of the EWTD. The UK was the only Member State which insisted on its inclusion. It must be voluntary in order to prevent the employer achieving "by subterfuge or through intimidation, a situation whereby the employee renounces the right for his weekly working time not to exceed the maximum laid down" (Advocate General Ruiz-Jarabo Colomer, Pfeiffer v Deutsches Rotes Kreisverband Waldshut eV (2003)).

A review by the European Council of the opt out in practice cited findings by the CBI (2003) which revealed that as many as 33 per cent of all workers in the UK have signed an agreement; this figure constitutes more than double the number of those who on average work more than 48 hours per week (COM 2003). Neathey and Arrowsmith (1999) found that three-quarters of workers were actively being encouraged to sign the opt-out. Taylor (1998) further reported that as many as 74% of employers said they would be asking some of their existing employees to exclude the Directive. Evidence suggests that employers use the opt at the point of hiring, that is the formation of the employment contract (Barnard *et al.* 2003), which deprives workers from participating in an equal bargaining process at the stage of their employment relationship when they are most vulnerable (Kenner 2004). In a later study, Neathey and Arrowsmith (2001) found that from a total of twenty organisations, sixteen had employed the opt-out provision whilst eight had made or planned to make some changes to working patterns. Their follow-up study (Neathey 2003) revealed that only one firm from the original sixteen using the opt-out had since ceased employing the derogation.

The opt-out has therefore significantly diluted the regulatory stimulus for UK employers (and trade unions) to implement changes in work organisation practices (Barnard *et al.* 2003;

Neathey 2003; TUC 2003c; COM 2003). Partly as a result of this and in light of the ECJ rulings (see chapter 5), the European Council commenced consultations to amend the EWTD on 20 October 2004 (COM 2004), and the Commission subsequently adopted a proposal on 22 September 2004. The draft legislation proposes to extend the reference periods for calculating maximum weekly working time to 12 months. It also retains the individual opt-out, but its application is qualified by set of conditions which must first be satisfied. For example, the opt-out should be implemented by way of collective agreement or by national law, and both employers and employees are obliged to consider other flexible options before using the derogation.

Member states must maintain records registering the actual hours worked, and employers must ensure that no worker works more than 65 hours a week unless otherwise provided for by collective agreement. This would have addressed the worst excesses of long working hours while acknowledging the complexity and difficulty of regulating weekly working time in the UK (Rojot 1998). Furthermore, the Commission's proposal acknowledges that, in Britain at least, many workers do not want to have their working hours limited by regulation and are motivated to work long hours for overtime pay, the prospect of promotion, and higher rewards in the future or a sense of autonomy in managing their own working time (Barnard *et al.* 2003; Kodz *et al.* 2003). The fact that many workers do not necessarily perceive the 48-hour limit as a desirable policy objective perhaps helps to explain the limited impact of the EWTD on weekly working hours in Britain (Hobbs and Njoya 2005).

The draft legislation also incorporates a new definition of working time in light of the uncertainty which has resulted from the ECJ case law (see chapter 5) and, in line with the judgments, it defines on-call time as the period during which the worker has the obligation to be available at the workplace in order to intervene, at the employer's request, to carry out his activities or duties. An inactive part of on-call time is also defined as the period during which the on-call worker is on call, but is not required by his employer to effectively carry out his activity or duties (COM 2005).

The proposal was endorsed by the European Parliament on 11 May 2005, however the difficulties on obtaining consensus among all Member States has been highlighted by the inability to obtain a qualified majority in a series of Council meetings in December 2007, November 2006, 2 June 2006, December 2005, and June 2005. The continuation of the opt-out after the political deadlock over the issue has therefore represented a tactical success for the UK (Watson 2007).

The UK Regulations initially required the employer to keep detailed records of the hours of both workers who had waived their entitlements to the 48-hour week via the opt-out, in addition to those who had decided not to do so. The government conceded to employers' arguments that this procedure was overly-burdensome and subsequently amended the provision so that the Working Time Regulations 1999 now only oblige employers to merely keep a record of workers who opt-out. In the view of the Commission, this does not accord with the intention of the Community's legislature (COM 2003), and may provide a basis upon which infringement proceedings against the UK could be initiated.

The Regulations' enforcement is split between different authorities. The weekly working-time and night-work limits, health assessments and record keeping requirements are policed by the Health and Safety Executive (HSE), local authority environmental health departments, and some sector-specific regulatory bodies. However, discussions with a senior policy advisor at the HSE revealed that budget restrictions have meant that there are only nine Working Time Officers in HSE. He confirmed that the decision to prosecute was made in accordance with the Health and Safety Commission's Enforcement Policy, and was largely reserved for the most serious breaches. The onus of enforcing rest and leave entitlements are left to the individual and/or his or her trade union through employment tribunals or collective mechanisms. Workers whose entitlements are denied or who suffer detriment as a result of asserting their working-time rights may make also make complaint to the tribunal. Section 101A of the Employment Rights Act 1996 specifically provides employees with protection against unfair dismissal if they are dismissed for exercising their right not to work beyond the limits contained in the Directive.

The statutory regulations have therefore empowered individual workers to a certain degree. Recent case law in the UK has demonstrated this point. In contrast to its conventional policy

of non-intervention with employment relations, the judiciary has acknowledged that the contractual terms relating to hours of work must be exercised in the light of other implied contractual terms such as the employer's duty to take care of the employees' safety. One such case – Johnston v Bloomsbury Health Authority [1991] – involved a doctor regularly working in excess of 100 hours per week despite a contractual obligation prescribing 40 hours per week. Shortly after the Johnstone ruling, an industrial tribunal in Bury St Edmonds ruled that it was unreasonable for an employer to dismiss a worker who refused to work 12 hours a day for seven days a week (George v Plant Breeding International (Cambridge) Ltd [1991]). In response to the EWTD in particular, the High Court has declared that the regulation's provisions represent an express contractual duty which should be recognised between all employers and their employees (Barber v RJB (1999).

Employment Relations

The twin themes of competition and flexibility have been a common feature of both Conservative and New Labour policy since 1979, though their approaches to manifesting these ideologies in practice have differed (Deakin and Wilkinson 2005). To highlight the differences and similarities between the two governments, this subsection looks at the priorities and sources of working-time controls and analogous rights by reference to their origin, market regulation and trade union participation. By providing this context, it will address one of the study's objectives which is to analyse the views of elite stakeholders about the political and legal debates surrounding the regulation of working time.

Internationalisation, Europeanisation, and globalisation transfer the decision-making capacities to supranational bodies, such as those in the European Union (EU) (Held 1995). Traditional state sovereignty is therefore eroded, particularly with the implementation of uniform laws binding numerous Member States. Discretionary actions and policies must consequently submit to new intensified forms of surveillance, monitoring, accountability and enforcement (Jessop 1997). Such systems of legal regulation are oblivious to state boundaries, illustrating the "distance that has been travelled from the classic, state-centric conception of sovereignty to what amounts to a new formation for the delimitation of political power on a global basis" (Held 2002: 11). Such 'outside arrangements' force internal processes within the nation-state to reconstruct their own rules, thus posing a set of "legal irritants" to the existing organisation (Teubner 2004). Some commentators believe that the

sheer diversity between different states in terms of legal systems and cultures exacerbate such difficulties (Legrand 1995, 1997).

The Conservative governments of the 1980s and 1990s were keen advocates of the principle of subsidiarity, and that both regulation and accountability should be vested within local jurisdictions (Bishop and Mayer 1995). The decentralisation of the NHS, discussed in chapter 4, is modelled upon the same notion. Local authorities were seen as being better informed than highly centralised systems about the needs and preferences of those citizens who were affected by the regulatory intervention. In the context of working-time regulation, the Conservatives therefore believed that individual Member States were better equipped than supranational authorities to address such fundamental working conditions, particularly given its concerns surrounding the impact of a regulated market on its competitiveness:

> Prime Minister Thatcher considered it quite inappropriate for rules and regulation about working practices or welfare benefits be set at the Community level.
>
> Thatcher 1993: 750.

The government was not in principle opposed to the extension of health and safety protection to the workforce. The Redundancy Payments Act 1965, passed under Harold Wilson's Labour government, provided industrial tribunals with jurisdiction to deal with cases of redundancy. However, Edward Heath's Conservative Administration introduced further individual employment rights under the Industrial Relations Act 1971, and extended the tribunal's authority to cover such rights (Davies and Freedland 1993). Rather, the Conservatives were against the changes imposed by EC initiatives which, in its opinion, did not take account of the working of the market and the likely impact on labour costs (Napier 1991). This was demonstrated by their consistent opposition to working time regulation and similar socio-economic policies proposed by the EC (Hantrais 2000). This helps to explain the relatively slow pace of European social legislation, and arguably why workers in the UK were faced with comparatively poorer pay, protection, control, employment rights, and longer working hours than the European workforce (Blair *et al.* 2001; Ewing 1996).

New Labour, in contrast, committed the UK in 1997 to both the Social Chapter and the Amsterdam Treaty. The latter was aimed at encouraging competitiveness and entrepreneurial

freedom among EU Member States as part of a broader obligation to make the labour market more flexible (Adnett and Hardy 2001). It implemented the EWTD upon assuming office and has since transposed other similar EC legislation (see below). However, it has also attempted to block and/or limit the impact of other measures aimed at protecting workers. These have included rights on equal treatment for agency workers; information and consultation of employees' representatives in the undertaking; and other trade union rights, such as collective bargaining, collective action and strike action contained in the EU Charter of Fundamental Rights and the draft EU Constitution.

New Labour's lukewarm approach to EC legislation supports the argument that a radical change of vision on industry regulation since the Conservatives left office has not occurred (Barnard *et al.* 2003), though it does distinguish the governments' use of market regulation to control fundamental work conditions. Conservative policy on promoting individualism and deregulated markets (Dawson *et al.* 1988) while at the same time attempting to reduce dependence on the welfare state can "be understood as a 'cultural crusade' to construct Britain as an enterprise culture" (Exworthy 1999). It was reinforced by the state's withdrawal of trade union immunities and legislation reducing statutory controls on industry. New Labour, on the other hand, has implemented maternity and paternity provisions; the National Minimum Wage legislation; the Flexible Regulations 2003; and the Employment Relations Act 1999. It has amended the regulations on redundancy, transfers of undertakings and embraced the extension of discrimination laws, and has implemented EC directives on the rights of part-time workers and working time.

The rhetoric of work life and flexibility is common to some of these provisions, but it is an area which has historically remained outside the EC's regulatory domain. Recent social action programmes, however, have made reference to the implications of changing patterns of family vis-à-vis employment and social protection systems (Hantrais 2000). The EWTD is a health and safety measure, but New Labour has used the regulation to underscore the importance it also attaches to work-life by arguing that fewer working hours translate into more opportunity to spend time on activities away from work (DTI 2002b; DTI 1998b). The DTI's highly publicised Work-Life Balance Campaign, launched in March 2000, highlights to employers the benefits of introducing innovative ways of working that meet the needs of the business and customers while simultaneously improving both the work-life balance and subsequent health of their employees.

The 'flexibilisation' of working time rests on a number of rationales that are generally driven by concerns for both business and employee welfare (Martino 1995). Better working relations, healthier workforces and improved productivity (Palmer 2004), and diversification to meet customer demand (Walsh 1997) are among the most frequently voiced. Nearly half the full-time British workforce report that they enjoy their jobs but cannot cope due to work pressure (CHI 2004; Barnard *et al.* 2003; TUC 2003c; White *et al.* 2000), long hours, unpaid overtime, and stress (TUC 2000; Guerts *et al.* 1999; MacErlean 1998; Allen *et al.* 1997; Ferri and Smith 1996; Allen 1994). A poor work-life balance can adversely affect personal relationships; many men, for example, do not feel that they spend sufficient time with their children (Amicus 2003). Demographical changes, including the sustained growth of the female and ageing workforce (Avery 2004) and the increase in men assuming domestic roles (Casey *et al.* 1997) has also elevated the interest of participation in a more flexible labour market.

Flexible working arrangements have been reported by just over half of UK employees (Palmer 2004; Cully *et al.* 1999), particularly among part-time and public sector workers. The number of non-standard employment in the public sector increased between 1984 and 1998 particularly those employed on fixed-term contracts (Millward *et al.* 2000). Short-term contracts were more common in public services than the private sector (Cully *et al.* 1999). The percentage of part-time workers in the public sector between 1995 and 2005 has been averaging 25 per cent and full-timers 70 per cent (Hicks *et al.* 2005). Only 10% of men work part-time compared with 44% of women (Bishop 2004). Women account for around 65% of employment in the public sector (Millard and Machin 2007). These trends have generally disadvantaged women economically, which continues to fuel occupational segregation insofar as women earn less than men and are less likely to occupy positions of high status (Worklife Program 2005). In addition to the continuing wage gap (BBC 2006) women with children in Britain lose as much as 57% of lifetime earnings after the age of 25 compared to her childless counterpart (Cully *et al.* 1999). One in five wants a better work-life balance but the majority fear that committing to such an approach would be detrimental to their career prospects (DTI 2002a).

The Flexible Regulations 2003 have attempted to address the situation, obliging employers to consider employee requests for flexible work options. The DTI has reported encouraging

signs of compliance having found employers to be granting 77% of requests to work flexibly from a total of 24% of requests made by parents with young children (Palmer 2004). The evidence, however, is not conclusive. Various polls (Worklife Program 2005; TUC 2004a) have found many requests to be rejected unfairly in practice, with those receiving their requests seeing their pay cut or their job status reduced to account for the more flexible arrangements.

Furthermore, the dominant form of flexible work continues to be overtime rather than more innovative work patterns (Barnard *et al.* 2003; Bell and Hart 1999; Casey *et al.* 1997). In the UK, over 5 million employees work overtime (TUC 2003a); the average number of hours of overtime worked per worker per week is 1.5 (0.7 for women, 2 for men) (Eurofound 2007). Overtime provides flexibility in production scheduling and can help to meet rush orders and unexpected changes in demand without any difficulties in finding appropriately skilled workers. It also serves to circumvent the legislative and financial costs of having to recruit and dismiss workers (Hart 1987). Informal and unpaid overtime arrangements that can lead to excessive hours are usually found in managerial, professional and some administrative jobs (Evans *et al.* 2004; TUC 2003a; Casey *et al.* 1997). Working long hours and overtime also appear to have a strong effect upon promotion prospects, thus limiting the incentive to comply with work time regulations (Cully *et al.* 1999; Booth and Francesconi 1997; Landers *et al.* 1996).

The general lack of success in achieving changes in working-time patterns has been attributable to a number of factors, including the difficulties of conducting voluntary negotiations without any legislative imperative to do so (and industry-specific regulation rather than a general statutory floor to basic working conditions), declining union membership, and members' fears of lower pay to correspond with fewer hours (Barnard *et al.* 2003; Cully *et al.* 1999; (Casey *et al.* 1997). Deakin and Wilkinson (2005) also point to the failure of collective laissez-faire; while having attained some working-time reductions, the bargaining system has not dealt with the over-reliance of both employers and workers alike on high levels of overtime. In this sense, the EWTD – "the most radical overhaul of labour market regulation" (CBI 2000) – reasserts the issue of hours on the employment agenda, while consolidating all relevant aspects of working time under one comprehensive statutory roof. For the UK, at the very least, there is essentially now only one point of reference, currently for most – but not all – sectors of the labour market.

Furthermore, the regulation presents trade unions with the opportunity to reinvigorate the issue of working time as part of their bargaining agenda. The European Commission's proposed amendments to the EWTD add impetus for collective negotiations over innovation in working-time arrangements, pay and productivity. For example, before Member States can extend the reference period to calculate the weekly working hours, there must first be a consultation of the social partners concerned and every effort made to encourage all relevant forms of social dialogue, including negotiation between the parties if they so wish. It will also be possible to derogate from the maximum weekly limit of 65 hours by collective agreement, and the Commission also proposes that the use of the individual opt-out will require prior authorisation by collective agreement or agreement between the two sides of industry at the appropriate level (Hobbs and Njoya 2005). The EWTD therefore demonstrates how regulation of the labour market provides a framework to support dialogue and negotiation between the key players in the development and implementation of employment policy and regulation. Commentators, however, have embraced the overall changes cautiously:

> The danger is overstating the impact of statutory regulation, for the fact is that employment relations tend to change relatively slowly and often in ways independent of the law. Increasing European integration is likely to further shape the course of British employment relations.
>
> Cully *et al.* 1999: 299.

Thus, attempts by the Conservative governments to limit the authority and influence of trade unions were reflected in legislation passed by the state to control their activities (Smith and Morton 2001b). By the time New Labour assumed office, two-thirds of private sector workplaces were without a union presence, and only one in four unions were recognised (EIRR 1998). However, the make-up of trade unions across the labour market is far from uniform (Scheuer 1999). The presence of unions is twice as high in the public sector (87.4 per cent) as the private sector (34.4 per cent) and union density of 59 per cent is over three times as high as the public sector (18 per cent) in 2003 (Palmer *et al.* 2004). Public sector union presence and influence therefore remains higher than private sector in terms of both density and policy (Prowse and Prowse 2007). Evidence by Bailey (1994) and Hicks *et al.* (2005) indicates that the policy of privatising nationalised industries and corporations reduced public sector union membership from 1.85 million members in 1979 to 0.38 million in 2005.

Whereas Conservative governments 1979-97 attempted to implement measures restricting the authority and influence of trade unions, New Labour has endeavoured to shape employment relations in a similar but more subtle fashion using the notion of 'partnerships' (DTI 1998a). For example, its Employment Relations Act 1999 legislation provides a statutory procedure under which an independent union may establish a right to recognition for the purposes of collective bargaining. In 2001 there were almost three times the number of recognition agreements reported than in the previous year; more than 470 new recognition agreements were signed, of which 450 were voluntary. The TUC estimates that more than 120,000 workers have been covered by new deals over the 12-month period to October 2001 (EIRR 2002). Looking at the issue over a longer period, between 1995 and 2002, recognition agreements were struck covering around one million workers, against decisions to derecognise covering just 60,000 workers (Gall 2004). The legislation, however, is limited in both its scope and influence on employers (Deakin and Wilkinson 2005). Drawing from their research on the statutory recognition procedures contained in the 1999 Act, Smith and Morton (2001a; 2006) argue that in the light of recent labour-market regulation, the overall role of collectivistic representation has been limited in the statutory provisions implemented by New Labour, thus indicating a continuation of Conservative ideology vis-a-vis union influence in labour market regulation:

> New labour has developed a distinctive form of neo-liberalism in which Conservative legislation on trade unions and industrial action has been integrated within a more subtle discourse of social partnership and collective and individual rights, and carefully defined intervention in the labour market and the employment relationship is designed to promote efficiency.
>
> Smith and Morton 2006: 23.

The unions' marginalisation – initiated by the Conservatives and continued by New Labour – is set against the context of plethora of legislation strengthening the rights of individual workers. The wider discontent among unions towards the present government, is illustrated by the rise in working days lost in the public sector due to industrial disputes between 1997 and 2003 (Blyton and Turnbull 2004) over which the majority concerned pay. The emergence of strategic and high-profile conflicts therefore shows that relations based on New Labour's concept of partnership are less than clear.

Further similarity between New Labour and the Conservative governments can be seen in the former's goal to maintain maximum capital and labour-market flexibility. While New Labour has indeed adopted far more family-friendly policies and European regulation than the Conservatives through implementing a series of legislation, the measures have been distinctly minimalist in form. Thus, the EWTD transposed into UK law has contained all of the derogations that were negotiated by the then Conservative Secretary of State, Gillian Shepherd, and has not addressed the issue of overtime. The Information and Consultation Regulations, which similarly implement an EC Directive, establishes a right of employees to receive information and to be consulted, but unions are largely excluded from the process, particularly in the smaller organisations, and the protections are narrow (Smith and Morton 2006). The National Minimum Wage Act 1998 has not escaped criticism either. It has, with very few exceptions, set a basic hourly rate covering the entire employed labour force, but the figure is not uprated without consultation. Furthermore, the initial rate was below an employment-weighted average of the rates last set by wages councils in the early 1990s. The impact has not, in the view of the Low Pay Commission (2003) been significant. In this respect, Barnard *et al.* (2003) synonymise New Labour's concept of flexibility with a form of freedom from external constraints. It is also unclear whether the relevant measures would have been taken in the field of working time and similar legislation had it not been for pressure from the EC (Deakin and Wilkinson 2005).

Conclusion

This chapter has demonstrated how Britain's historical approaches to regulating both employment conditions and relations have contributed to comparatively long working hours across the UK labour market. Paradoxically, the 'welfare' state has, to this day, reserved a distinctly minimalist role in the protection of its workforce by failing to impose general statutory controls which address some of the longest working hours experienced in the EU. The EWTD's implementation is basic in form, and Britain's complete application of the legislation's derogations has diluted its potentially significant impact on long working hours. We are therefore left with a 'hybrid' situation which does not conform to the rigour and strict parameters of an influential regulation; nor is there an expansive scope for trade unions to collectively bargain with employers regarding working time.

In line with the study's overarching aim, this chapter has explored the historical modes of regulating working time from voluntarism and collective negotiation to statutory control. It reflects the concerns raised by all three research objectives, namely the political and legal debates surrounding the regulation of working time; the implementation and enforcement of the EWTD; and, its apparent impact. These broad discussions set the scene for the study's particular focus on the medical profession, and raise a series of questions. How will the medical profession, as a body of workers definitively governed by self-regulatory and voluntarist mechanisms, respond to statutory controls such as the EWTD? As its main trade union, what influence will the British Medical Association (BMA) have on the process of implementation, and its members' compliance? Will there be room for continued negotiation on doctors' labour conditions, in light of the restrictions placed on the general labour market? The next chapter explores these issues in more detail, focusing on the profession's historical (and quickly evolving) relationship with the state, which has shaped the conditions of work in medicine. In light of this study's objectives, the general discussions surrounding the various modes of regulation, mapped out in this chapter, are therefore applied specifically to the medical profession.

Chapter 4

Modes of Regulating the Medical Profession

Introduction

The chapter sets the context for the study by examining the different modes of regulation that have governed doctors' workplace relations. It maps the transition in state activity from that of laissez-faire to an approach which nowadays intervenes more directly on the workplace relations within which the medical profession practices. It explores the state's predominant ideological and rationalisation philosophies that underpin its regulatory intervention and NHS modernisation strategies. While the chapter makes reference to the more recent emphasis on clinical governance, it is predominantly concerned with the regulation of workplace relations, with a particular focus on work conditions and pay, in line with the study's overarching aims. There are, nonetheless, instances in which state intervention has arisen as a result of a combination of both clinical and workplace concerns. Whilst there is a distinct overlap between these two aspects, the discussion attempts to distinguish between the two forms of regulation.

The focus on the different modes of regulation and their respective 'regulators' – the profession, managers and the state – is complemented by an analysis of the wider political and economic context in which the medical profession and their employers are located, to gain a fuller understanding of the process of employment relations reform. This account is key to our understanding of the response of the profession to the issue of regulation, particularly in light of the study's specific focus on the EWTD. This corresponds with the objectives posed by the research, namely to analyse the views of elite stakeholders about the political and legal debates surrounding the regulation of working time in a particular professional sector, and to examine critically the ways in which the regulations have been implemented. The discussions contextualise the struggle for control between the state, on the one hand, and the profession on the other.

The problem of regulation

Medical professionalism rests on three key characteristics which together constitute the basis of doctors' longstanding autonomy: expertise, ethics, and service (Irvine 1997). The former derives from a body of knowledge and skills that non-professionals are not necessarily

equipped to evaluate or regulate, and whose utility is constantly invigorated by the results of research. Ethical behaviour flows from a unique combination of values and standards which are governed by a disciplinary and ethical code. Service embodies a vocational commitment to put the interests of patients first. In its report 'Doctors in Society: medical professional in a changing world', the Royal College of Physicians of London defined medical professionalism as "a set of values, behaviours and relationships that underpins the public trust in doctors" and lists the qualities doctors should strive for as integrity, compassion, altruism, continuous improvement, excellence, and multidisciplinary working (RCP 2005; Tallis 2006). Professionalism, according to the report, codifies the idea that a doctor's responsibilities go beyond a mere contract of employment, and encapsulates the notion of partnership between patient and doctors. It will be argued below that a strained partnership between the medical profession and the state which developed in the latter part of the twentieth century has consequently led to the profession's regulation by way of new public management.

In spite of the references above, there is a notable absence of a succinct definition of what generally constitutes a profession or a professional. Early work about the nature of professions and professional organisation were dominated by an approach which attempted to delineate the key characteristics or traits that were held to constitute a profession. Greenwood (1957), for example, identified five distinguishing attributes of a profession: systematic theory, community sanction, authority, an ethical code and professional culture. The difficulties of identifying agreed traits between the various professions has led in more recent times to literature on the sociology of professions drawing on the classical theories of Marx and Weber (Freidson 1994; Johnson 1972; Larson 1977). Here, the central concern is not with the identification of archetypal features of a profession, but with the range of ways in which professions, as particular kinds of occupation, conduct themselves. These include the role of abstract knowledge, processes of social closure, historical negotiations and collectivism, and a service ethic (Ashworth *et al.* 2002). Each of these features are applied to the medical profession in turn, in an attempt to understand the historical modes of regulating doctors, which forms the second part of this chapter.

At the heart of every profession is a legally sanctioned control over a specialised body of knowledge. Medical knowledge is generally specialised, complex and incomprehensible to the lay person (Cruess and Cruess 1997):

> Medical practitioners claimed, and claim, the uniqueness of their body of knowledge and set of skills; only they have this knowledge, the profession is cognitively exclusive.
>
> Stacey 1992: 205.

In its use of medical knowledge, the medical profession has earned a relationship grounded on trust with society, and in return has been afforded a privileged position by the state manifested in clinical autonomy (Freidson 1970b; Merrison 1975; Stacey 1992; Lupton 1997). Such knowledge therefore represents the cornerstone of medical professionalism (Evetts 1998), occupational dominance and autonomy in this sector of the labour market:

> This startling growth of knowledge forms the foundation for the rise of medical power.
>
> Furst 1998: 12.

Some commentators argue that, with the computing age and access to information over the internet and through the media, doctors no longer possess a monopoly over medical knowledge (Coiera 1996; Irvine 1997; Tallis 2006). Lay people are also able to gain knowledge hitherto confined to an elite group of experts through self-help groups concerned with particular diseases, disabilities and other health problems. Contributing to the loss of exclusive knowledge is the rise of clinical regulatory bodies, administrative audits, clinical governance, monitoring, evaluation programmes and performance indicators associated with the ascendancy of managerialism and bureaucracy in healthcare (Berg 1997).

These arguments were addressed by Haug (1973), who felt that the number of professions and the strength of professionalism would decline in the future. She dealt specifically with medicine, stating that it was becoming deprofessionalised. Increased specialization had caused fragmentation of the body of knowledge, and then fragmentation of the profession itself, as different organizations commanded the allegiance of groups of physicians. She stated that information technology and the education of the public have increased the accessibility of knowledge, therefore decreasing the power of medicine over its knowledge base. The development of other healthcare professionals with comparable skills such as physician assistants, was also diminishing medicine's dominance (see chapter 5).

Writing ten years after this original publication, Haug (1983) looked at the issue again, and found that these concepts were still valid, but that deprofessionalisation had not taken place to the degree she expected. Similarly, Cruess and Cruess (1997b) argue that it has occurred, but it is not a significant factor. Rather, they claim that the principal threat to medical autonomy is corporatization and bureaucratisation. The process of bureaucratization involves the subordination of practitioners, patients or institutions to a hierarchical structure outside the profession (Weber 1947). It is largely external, and takes place either in the state or the corporate sector with the overarching aim to implement cost control. This, however, is not characteristically associated as an objective of the medical professional sector.

An equally significant argument, and one which has similar connotations to deprofessionalisation, has been put forward by McKinley (1982). He felt that medicine was becoming 'proletarianised.' This refers to a process whereby medicine loses control over the context and content of medical care because of the bureaucratisation and corporatisation of health care. For example, the rationing of medical services implemented by the state in light of the bureaucratic monitoring of clinicians' behaviour has subsequently impinged on the latter's ability to prescribe patient care free of any financial constraints (Coburn *et al.* 1997).

McKinlay and Marceau (2002) provide further examples how a variety of extrinsic and intrinsic forces have contributed to the decline of medical dominance in such a way. Extrinsically, the changing role of the state and its loss of historically institutional support for doctoring have substantially impacted on the medical profession's autonomy, as have other factors such as the bureaucratisation of doctoring. The emerging competitive threat from other health care workers who are able to effectively provide the same medical services but at a cheaper rate than doctors not only satisfies the state's rationalisation policy, but it also expands the traditionally monopolised medical knowledge base, referred to above. Globalization has affected medical dominance by permitting increased mobility of physicians between countries (and particularly in the EC), and multiplying the available sources of medical information which are consequently empowering patients, stripping doctors of their monopoly on medical knowledge, and subjecting their monitoring of their everyday behaviour. Intrinsically, and in the US in particular, there is an oversupply of physicians which is consequently weakening the physician's labour market position (for a contrasting

perspective in the UK, see Fox (2007)). The fragmentation of the physicians' union through speciality and subspecialty differentiation is also having a similar effect.

McKinlay's arguments on the corporatisation of medicine largely refer to the way in which the medical profession is organised in the U.S. (Hafferty and Light 1995). He claims that physicians are workers in a capitalist society and must sell their services, and that this competitive environment leads to a decrease in remuneration and professional autonomy. However, the majority of health care in the UK is not of a private nature, therefore for this strain of his argument, is has limited application in the UK.

In spite of these trends, however, the state continues to draw on the professionals' expertise (Kendall *et al.* 1996), particularly since the recent expansion in the regulation of clinical activity requires such knowledge (Flynn 1999). Many of the new mechanisms are run by the doctors or are heavily dependent upon their advice and knowledge (Davies 2000). The essence of medical expertise means that doctors therefore remain crucial to informing health policy (Hunter 1994). Unlike most other sectors in the labour market, it has enabled them to monopolise the conditions and delivery of health of health care, and to negotiate advantageous working conditions with policymakers at a centralised level using a strong bargaining hand (Salter 2002). The result of such negotiations has, until the mid-twentieth century, guaranteed for them a history of self-regulation with very few attempts to externally control their conditions of practice. Freidson (1970a, 1970b) emphasises the overall influence medical professionalism on state policy in this respect:

> [Medicine's] pre-eminence is not merely that of prestige but also that of expert authority... it has an officially approved monopoly of the right to define health and illness and to treat illness.
>
> Freidson 1970b: 5.

Maintaining this state of affairs has been facilitated by the British Medical Association and the General Medical Council (GMC), the primary professional bodies representing the vast majority of all practising doctors. Their presence and membership represents a collective

power inherent in the profession to which the majority of other labour market sectors cannot compare (Stacey 1992).

Another defining feature of the profession is its social closure and a restricted access to its resources and opportunities (Beardwood 1999; Coburn 1993). The medical profession is a fiercely competitive and self-recruiting sector, to which entry is gained by a select few. This, in short, benefits the profession by ensuring that opportunities for income, job security and other privileges such as the capacity to control work and resources within employing organisations are maintained (Larson 1977). The state has been instrumental in reinforcing this phenomenon by severely restricting the funding and number of training places at UK medical schools, thus helping to limit the supply of qualified practitioners (Kirkpatrick *et al.* 2005). The GMC and royal colleges try to insulate the UK labour market from the external market; for example, overseas doctors must satisfy the GMC that their medical qualifications are from approved universities (mainly from the Commonwealth and Europe) or take an examination in Britain, and are also required to show that they have expertise in the English language. Fox (2007) argues that the government's establishment of the NHS together with professional licensure by the GMC and the way that it is administered has consequently created a bilateral monopoly, but this has failed to meet a sufficient supply of medical staffing and consequent patient demand (staffing is discussed in more detail in chapter 5).

Members of the closed profession have traditionally shared a common background, thus enabling both a homogeneity and continuity in group outlook on matters such as state regulation and health policy. Historical self-regulation and clinical autonomy have, for example, equipped the profession with a "groupthink" (Kirk-Smith and Stretch 2003) that doctors should be able to practice free from general governmental statutory intervention (Freidson 1970a). In similar vain, the conventional exclusivity attached to the profession's membership also serves to nurture particular values among its newest recruits at medical school. Assisting this process is the intense socialisation between medical students during the years spent in education and training on the one hand, and their dissociation from other 'lay' students on the other:

> They become immersed in the culture, the environment and lifestyle of the school. They slowly lose their initial identity and become redefined by the new situation.
>
> Shapiro 1987: 27.

Thus, medical students' and junior doctors' long hours demanded by both their training and service lead them to share common experiences within a unique working environment which tend to exclude other non-professional influences, including university students, peers, lay workers and members of the allied health occupations (Stacey 1992; Kirk-Smith and Stretch 2003), and consequently shape certain ideals within the parameters of a closed community of professionals (Coburn and Willis 2000; Kirk-Smith and Stretch 2003). There is little doubt that significant exposure to their professional colleagues leads the individual to acquire the cultural norms and values of that group which shapes their attitudes (Elliot 1972; Ginsburg *et al.* 2005), and medicine is no exception (Freidson 1970a). Becker (1961) and Merton (1957) drew attention to the medical school as a social medium in which students adopted the conceptions surrounding their expected professional roles from their seniors:

> *It is their function to transmit the culture of medicine and to advance that culture.* It is their task to shape the novice into the effective practitioner for medicine, to give him the best available knowledge and skills, and to provide him with a professional identity so that he comes to think, act, and feel like a physician.
>
> Merton *et al.* 1957: 7. Emphasis added.

Becker *et al.* (1961) emphasised amongst other things the interactionist interplays between students and instructors. More recent literature supports the replication of work roles and expectations between senior and junior doctors (for example, Van de Camp *et al.* 2004; Stacey 1992). Haas and Shaffir (1987) and Huntingham (1957) argue that medical students are constantly observing their supervising clinicians and tutors and listening to their philosophies, which allow for the reprocessing and continuation of ideas, imagery and work practices which exist in the profession:

> The physicians with whom they practice their clinical skills become models after which students pattern their own beliefs and behaviour.
>
> Haas and Shaffir 1987: 77.

Such identities and professional perceptions are therefore recycled between generations of doctors, giving rise to a distinctive and exclusive cognitive identity (Sinclair 1997a).

Acquiring an identity over a long-term process during which the learner develops the skills and knowledge is encapsulated at medical school (Hilton and Slotnick 2005). The exclusive nature of the medical culture highlights the difficulties presented to 'outsiders', including hospital managers and the state, in penetrating this group in order to modify its members' views, working relations and practices. There is evidence, however, to suggest that the medical culture is evolving. The profession is now diversifying at extraordinary levels. In almost every country doctors come from various cultural, ethnic and economic backgrounds. Though this represents an advance in terms of equity and fairness, it makes the transmission of common values more difficult (Cruess and Cruess 1997). In time, this trend may fragment the universal perceptions which gel members of the profession together.

Professionalism is therefore a multidimensional phenomenon that embraces a number of facets (Van de Camp *et al.* 2004). For the medical profession, each is explicitly linked by doctors' self-regulatory mechanisms which preclude state control (Harrison and Pollitt 1994). This has historically demarcated the status of the medical profession from other comparable professions in law, the senior ranks of the military and the Church. Its relationship with the state and monarch is particularly distinguished (Sinclair 1997b): judges acted in his or her name; the military fought his or her battles; and, churchmen maintained his or her spiritual authority. There is no comparable link with the medical profession. Rather, the Medical Act of 1858 resurrected the Hippocratic Oath which permitted the profession to swear allegiance to itself rather than to the Crown.

Autonomy has given doctors, individually and collectively, the clinical freedom to determine the standard of professional practice and education, the organisation of medical work, and discipline. At the most basic level, self-regulation underpins the concept of this conventionally autonomous profession. The two are inextricably linked. The 'problem' of the EWTD is that it does not conform to these traditional processes. By its very nature, external statutory controls conflict with the essence of self-regulation. How will the profession respond to the legislation? A degree of opposition is predictable given doctors' historical mode of governance, but will the occupational culture be sufficiently united and organised to withstand the law? The next section outlines the inroads paved by the state towards the regulation of doctors with primary reference afforded to the control of their work conditions.

Different modes of regulation

Different modes of regulation have governed the medical profession's conditions of employment from the inception of the BMA and the medical register in the nineteenth century, to the present day. There are three modes of regulation: self-regulation, as the mode of governance to which doctors have historically been accustomed and has been a defining feature of their professional status; the implementation of new public management; and, statutory controls, with particular reference to the European Community's (EC) intervention on health policy and doctors' working conditions in the NHS. For illustrative purposes, there is some reference to the recent emphasis on the medical profession's clinical governance to demonstrate the state's increasing intervention in a labour-market sector that has conventionally been self-governed and relatively free from such external scrutiny and control.

Self-Regulation

The ability to undertake one's work free of state strictures and external regulation has long characterised the 'professional' (Freidson 1970a, 1970b, 1994). Professional organisations are perceived as being equipped with the necessary expertise to deal with the everyday regulation of its members, and have largely existed to serve their best interests:

> Thus the characteristics of professionalism such as autonomy and self-regulation help to produce a situation in which the practice of specific skills can be retained as a monopoly within the profession, helping to keep earnings higher, and career prospects better...
>
> Harrison and Pollitt 1994: 2-3.

Self-regulation is therefore self-serving not only in terms of the limited strictures on one's professional approach to work, but also for the personal benefits and protections it affords to its members. In line with these tendencies, doctors have largely been able to arrange their work to suit their own clinical and intellectual preferences without fear of external state intervention. Clinical autonomy is a variant of the self-regulatory model which applies almost exclusively to the medical profession. In essence, it is a doctor's capacity to diagnose and treat his or her patients free of prescribed clinical guidelines, reviews, audits and 'performance indicators' (Harrison 1990a). Such control over the nature and volume of medical work has helped doctors to resist 'management' in the industrial sense. BMA surveys

have consistently found an overwhelming support among UK doctors for such clinical independence (Cooke and Hutchinson 2001). One survey of more than 2000 trainee doctors and medical students found that external factors such as attaining state and management-led targets reduced their autonomy, and many would consider leaving the profession if these continued (Kmietowicz 2005). For these sectors of the workforce, there is no incentive to accept state regulation, and this view partially explains why a proportion of professionals oppose it:

> Legislation and administrative guidelines conflict with professional autonomy by regulating areas of work or expertise that professional actors consider within their exclusive jurisdiction. They thereby seek to defend their professional project from what they see as inappropriate legal/government encroachment.
>
> Anleu 2001: 420.

These tensions are able to be understood by reference to the historical mode of self-regulation which has traditionally governed the profession's approach to their training and service. The sequential analysis of doctors' self-regulation is discussed next by reference to their institutional self-regulation; their collective self-regulation; and its cost.

Institutional self-regulation

It was not until 1518 that the College of Physicians of London was formed to exercise control over the licensing and examination of physicians (surgeons subsequently separated from barbers and established the London Company of Surgeons in 1745, eventually becoming the College of Surgeons in 1800). Ironically, professional self-regulation in medicine truly took form by legislative intervention with the passing of the Medical Act of 1858. It created what is known as today's General Medical Council. It was a body composed of medically qualified representatives of the licensing bodies and the universities, with a few nominations by the Privy Council, formed to supervise the activities and training of the profession (however its composition is very different today). Its purported aim continues to be the protection, promotion and maintenance of the public's health and safety by ensuring the formation and implementation of proper standards in medical practice (GMC 2007). The law provides four main functions under the Medical Act of 1858 which include keeping up-to-date registers of qualified doctors; fostering good medical practice; promoting high standards of medical education; and, dealing firmly and fairly with doctors whose fitness to practise is in doubt.

Where any doctor fails to meet the GMC's standards, it acts to protect patients from harm – if necessary, by removing the doctor from the register and removing their right to practise medicine.

Despite the aims of the legislation, the 1858 Act was also a strategy advocated by the profession to address the nineteenth century's overcrowded medical profession which comprised of both unqualified practitioners together with those who had undertaken relatively lengthy and expensive training. In addition, it sought to tackle the inadequacy of medical education by standardising the necessary qualifications, and it unified the practitioners under one regulatory body (Moran and Wood 1993). The existence of a medical register meant that market entry into the profession was restricted. The legislation was therefore a tool to minimise competition and maximise both opportunities and profits between those claiming medical status. Furthermore, the register served to equalise the status of practitioners bringing all local and diverse practises under the control of a centralised system, and facilitated the unity and exclusivity of an authoritative and powerful medical profession by containing most expert medical knowledge to one particular sector in the labour market (Stacey 1992). A dominant professional group therefore emerged supported by a state-sanctioned system which served the interests of its members, and one that monopolised its knowledge and skills to which only an exclusive few could access.

Doctors were therefore immediately and distinctly advantaged if they appeared on the Medical register. It would control the supply of medical professionals for one, but more importantly it was only those whose names were listed could take up posts within government-administered services (Jones 1974). This is significant when considering the profession's influence over debates with the state over the National Health Insurance scheme in 1911 and the National Health Service Act 1948. The partnership between the BMA and the state afforded the former with cooperation and consideration by the Department of Health, while the latter could achieve considerable advantage from the support and technical knowledge provided by the Association. As such, the BMA has conventionally enjoyed a position of considerable strength within the negotiating committee.

In line with its laissez faire and voluntarist policy, the state "lack[ed] interest in controlling medicine and health" (Macdonald 1995: 77), which consequently resulted in hospitals falling under the control of the doctors (their authority remained as dominant until the latter part of

the twentieth century). Its corresponding lack of intervention in medical higher education allowed hospital doctors to secure a central position in medical learning, which they retained when the teaching hospitals gradually became incorporated into the universities (Freidson 1983). This control was and continues to be exercised to a significant extent today through the Royal Colleges which regulate all post-qualifying exams. The state's intervention during the latter half of the nineteenth century was chiefly in a piecemeal fashion through the operation of the Poor Law Board and the Public Health Act of 1872. Its abolition of the General Board of Health in 1854 meant that until the establishment of the Ministry of Health in 1919 there was no central state agency dealing with health. It is during this time that the position of doctors strengthened by their majority presence on the statutory GMC and by their domination over the growing number of hospitals (Macdonald 1995).

The 1911 National Insurance Act was one of the state's first attempts to intervene on the delivery of health care in the UK. The legislation was concerned with the provision of general practitioner (GP) services, and was an important element in the Liberal government's programme of social policy reform. It provided for free care by GPs for certain groups of working people earning under £160 per annum. By conceding to the profession's demands, the legislation was pushed through in spite of considerable opposition by doctors who were anxious about the degree of state control encroaching on their work, and of the possible financial consequences (Ham 2004). Doctors were persuaded into the scheme when the government agreed that payment under the scheme should be based on the number of patients on a doctor's list – the capitation system – rather than on a salary, thereby preserving GP's independence, and ensuring their relatively high remuneration.

Up until then, the system of health-care provision in Britain was based entirely on local initiatives and private provision. They comprised local practices developed by individual doctors (which subsequently became GP services under the NHS after the passage of the 1911 Act), and a system of local (municipal and 'voluntary') hospitals, many of which originated from the common workhouses established for the relief of poverty. Local authorities were not prevented from organising and providing municipal medical services in hospitals, but they mainly saw their role as organising local initiatives and providing some subsidy. However, from as early as the middle of the 1920s, medical services had been removed from the emerging national insurance system, necessitating subsidies from general public funds. This laid the foundations for the NHS, which continues to feature universal

health care provision, free at the point of delivery. The extent of the doctors' own movements, priorities, times and workloads continued to be determined internally by the profession (Harrison and Ahmad 2000). The wartime coalition government's 1944 White Paper stated that 'whatever the organisation, the doctors taking part must remain free to direct their clinical knowledge and personal skill for the benefit of their patients in the way which they feel to be best' (Ministry of Health 1944: 26, quoted in Harrison and Ahmad 2000: 131).

During the Second World War, in which there were mass civilian casualties, the government took steps to rationalise and control medical services for the duration of the hostilities. This arrangement continued after the war, gradually giving the state control of the health care system. Spurred also by the financial difficulties of the voluntary hospitals, coupled with the medical profession's hostility to municipal control (Bach 2004), the NHS emerged by the passage of the National Health Service Act of 1948, which provided, in effect, for the existing hospitals, their premises and other assets, to be nationalised. From that point on, they were to be administered by regional hospital boards under the general direction of the Minister of Health. The most important source of difficulty at the formation of the NHS was, like the circumstances surrounding the 1911 National Insurance legislation, accommodating the interests of the doctors, many of whom saw themselves as potentially being made into salaried employees of the state and thus under the latter's control. Hospital consultants were a source of particular problems (Kirkpatrick *et al.* 2005). Before 1948, both GPs and hospital consultants were mostly self-employed professionals. For them, the formation of the NHS represented a further encroachment by the state on their work. While the Act continued the responsibility for control over the technical side of medical care with the BMA and other professional bodies, the government negotiations paved clear inroads into the control over the terms of practice which were subsequently embodied into law to create a national system of organising and paying for health services. The Ministry of Health also took over the administrative and fiscal structure of health services, and thus the management of doctors' working hours and conditions.

The physicians' essential clinical autonomy, however, was preserved. They remained free under the new regime to prescribe exactly the remedy they considered to be appropriate, thereby maintaining clinical autonomy. Moreover, the hospital consultants were allowed to continue practising in a private capacity (including the use of NHS hospital beds for this), and were paid well for the numbers of patients seen under the auspices of the NHS. In addition,

there was a system of distinction awards that produced high remuneration for senior consultants and the possibility of important roles advising on the organisation of hospitals. Hospital specialists were not responsible to hospital management committees, but were contracted by regional hospital boards. They were therefore beyond the day-to-day control of hospital administrators and even the boards of governors of the hospitals in which they worked. Despite this, senior consultants were extensively co-opted onto hospital boards and were extremely influential in determining local policies and priorities. Organisationally, therefore, the NHS's original structure was highly centralised and bureaucratic, with political accountability at the top but little effective operational control on the delivery of health care. Dent (2003) argues that it was the medical professions that gained most from the NHS, quoting Eckstein's words (1958: 3) – the NHS was in effect 'a "doctor's measure" much more than a "patient's measure"'. The need to address this balance by alternatives modes of regulation became slowly apparent to the state in the years which ensued.

During the period from 1948-74, although there were clearly both bureaucratic elements in the administration (comprised by the ministry, the regional boards and the local administrative apparatus in hospitals themselves) and political influences (contributed by local elites being prominent in the management committees) professional power was pre-eminently strong. The clinicians were the dominant occupation, and their ideas and priorities overrode other concerns, such the inconsistent delivery of care across the country, the advances in medical research and technology, and chiefly the escalating costs of providing health care under the existing system (Pollitt 1993).

Collective self-regulation

Doctors have conventionally preserved their clinical autonomy and ability to inform healthcare policy without governmental intervention by way of their exclusive medical knowledge, closed community, and collective dominance represented by the British Medical Association. The BMA is the principal professional association for doctors in the UK. It is also a trade union, and negotiates all terms and conditions of service for every different group of doctors in the country (though doctors' pay is determined centrally by the state based upon the information supplied to it by an independent pay review body, the Doctors' and Dentists' Remuneration Body) (Jones 1981). For hospital doctors in training, the BMA's Junior Doctor Committee, which is made up of junior doctor representatives from all the English regions, Wales, Scotland, and Northern Ireland, has sole bargaining rights concerning junior doctors'

terms and conditions of service in employment in the NHS, including contracts, hours of work, and living and working conditions. It contains four main committees, namely the General Medical Services (for General Practitioners); Central Consultants and Specialists; Community Medicine and Health; and Hospital Junior Staff. Other BMA committees handle areas such as the impact of the European Community, medicine in the Armed Forces, university doctors, doctors and social work, and private practice (BMA 2007a).

It was formed in 1832 as the Provincial Medical and Surgical Association and only during the mid-1850s did it become known as the BMA. Until 1975 it retained a clause in its articles which legally restricted its adoption of trade union status. It was finally as a result of the 1974 Trade Union and Labour Relations Act that the Association was obliged to register as an independent trade union (Jones 1981). Though synonymous with the medical profession, the BMA does not possess any formal closed shop authority. In order to practise as a doctor of medicine an individual must be registered with the General medical Council but it is not necessary that he or she may be a member of the BMA (the other lesser unions relevant to doctors include the Medical Practitioners Union, the General Practitioners Association, the Junior Hospital Doctors Association, and the Regional Hospital Consultants and Specialists Association).

Specialities within medicine have been established and these are represented by a total of fourteen royal colleges. Each aims to further the development and devise the training requirements of their speciality. It is therefore quite consistent for doctors to be members of both a royal college and the BMA. Together with the Royal College of Nursing (RCN), the BMA is the most influential professional union in the NHS. Unlike many other trade unions, it does not rely exclusively on collective bargaining but instead attempts to control labour supply by limiting membership to registered professionals with an orientation towards the defence of job demarcations and long standing pay differentials (Bach 2004).

The self-regulation ideology permeating the medical profession at this time was replicated by the broader industrial trends of collective laissez-faire and autonomous collective bargaining. The policy, which developed alongside mass production techniques in the nineteenth and twentieth centuries, away from the master and servant relationship, implied two structural features which came to characterise the relationship between the state and the system of industrial relations. Firstly, there was no attempt to lay down a general legal model for

employee representation. Secondly, the law did not attempt to insert into the employment relationship a universal minimum set of standards. There was no general, legislative or statutory floor to wages and related terms and conditions. The unions therefore provided the representational machinery to ensure that the standards met the satisfaction of the workers employed in the relevant industries. The bargaining relationship between employers or employers' associations and trade unions was in this respect autonomous. Very few exceptions were made, and those which did come about were restricted to the laws on factory labour and the implementation of minimum rates of pay initially through trade boards and later by wage councils.

Legal regulation was therefore minimal. As employers were opposed to state intervention to underpin collectively agreed rates, the trade unions were similarly hostile to the involvement of the regular court system in the collective-bargaining process (Deakin and Wilkinson 2005). They, too, rejected a standard set of regulations for all trades, which explains why most employment legislation at the beginning of the twentieth century was partial and applied to a handful of industries (principally engineering, iron and steel, coal, cotton, and construction). Defining the British collective laissez-faire system was one comprising partial and uneven regulation through collective bargaining and the absence of a comprehensive statutory floor of rights to terms and conditions of employment, facilitated by the trade unions and employers' associations which were both highly local in character.

The cost of self-regulation

By the time of the Conservative government's election victory in 1979, there were large imbalances in state support given to different regions for the provision of healthcare. The proportion of funds allocated geographically reflected historical levels of provision, which in turn reflected the existing infrastructure such as the numbers of hospitals and their capacity, rather than the needs of the population (Kendall *et al.* 1996). The clinicians did not address such issues and, over time, inequalities of provision in different areas continued. The evolution of medical research had brought with it certain pressures on the existing system, such as the provision of new and costly medicines, thus expanding the parameters of medicine. The expense of developing technologies, in areas such as transplantations, radio-therapy and radiography, renal dialysis, limb replacements and intensive care, to name a few rose in line with the importance attached to medical research (Harrison and Pollitt 1994).

Such considerations were beyond the clinical ambit from which the medical professions undertook their work.

Such trends prompted concerns over the escalating costs not only within the realm of health-care provision, but along the public sector as a whole (Ham 1992). The economic crisis that followed the oil price increases of 1973 compounded the UK's relatively slow economic growth, while, at the same time, its aggregate expenditures slowly mounted across the public services, including health care, education, social security and defence. The NHS was beginning to feel the financial pinch of having to operate within a society that had increasing numbers of elderly people demanding health services (Pollitt 1993). The 'baby boom' in the 1960s had a corresponding effect on state funding in both the education and NHS systems. The NHS was therefore treating more patients than ever before (Farnham and Horton 1993). At the same time, an increase in (often poorer) one-parent families began to exert pressure on income maintenance and social work programmes (Pollitt 1993).

Any continued expansion of the welfare state could only be achieved by increased taxation and/or public sector borrowing. This had implications for private savings, investment and interest rates, which in turn had inflationary implications for the economy as a whole, thus affecting private willingness to save and invest (Farnham and Horton 1996). Staffing the various public systems generated large expenditures and with this, a discontent among the New Right with excessive bureaucracy. The number of non-industrial civil servants grew from 637,000 in 1960 to 698, 000 in 1970, and when Prime Minister Thatcher took office in 1979 the total stood at 738, 000 (Pollitt 1993). The Conservative Party, elected in 1979, argued that the bureaucracy in central and local government and the NHS meant that results were not produced in line with the growth in staff, and by 1988 the overall number of civil servants was cut to 590,000. Because of the lack of competition it was suggested that many public services were inefficient and wasteful, and the professions' monopoly over the system were only seen as serving their own advantage (Foster and Wilding 2000). New Right ideologies, on the other hand, favoured economic liberalism, unregulated markets, free enterprise and a deregulated economy. The desire to weaken the autonomy and power of the welfare professions (Bach 2004) and to make them more accountable for their actions was spurred on by professions' incapability of regulating their own practice (Kirkpatrick *et al.* 2005). These shaped the Conservative Party's approach to policy formation following its general election victory in 1979, and once elected it embarked on a number of policies which

sought better management using private-sector models. It was claimed that these would ensure that professional restrictive practices were progressively narrowed in scope and that individual professionals would fall more closely in line with overall organisational objectives:

> Lack of management control over professional service deliverers was a longstanding problem in many public services, and the new mood might just afford managers opportunities to tighten their grip on the more independent-minded doctors, lecturers, teachers and socials workers.
>
> Pollitt 1993: 47.

The private sector was held up as a model of economic efficiency, business competitiveness, wealth-generating enterprise and rational approaches to management (Pollitt 1993). Existing public services, on the other hand, were inefficient, self-interested and costly monopolies, but whose tradition of occupational control had precluded any state reform (Harrison and Pollitt 1994). Accompanying the state's economic policy was an emerging shift in political ideology about the role of the state and public policy. Regulating doctors and the delivery of health care through new public management – representing a fusion of private and public sector management ideas (Ferlie *et al.* 1996) – was perceived as one way of addressing the limitations of self-regulation.

New public management

Management is an activity that is intimately concerned with directing flows of resources to achieve defined objectives. These objectives are defined predominantly in the language of socio-economics. For the incoming Conservative government, managers were to address the mounting pressures in the NHS and the various limitations of self-regulation:

> Managerialism is a set of beliefs and practices, at the core of which burns the seldom-tested assumption that better management will prove an effective solvent for a wide range of economic and socials ills.
>
> Pollitt 1993: 1.

The definition of new public management (NPM) is a source of disagreement owing to its evolution over time, but it can be characterised, in the context of the NHS, as encapsulating the state's attempts to govern the medical profession's delivery of medical care by managerial supervision and regulation (Hannigan 1998). In line with Pollitt (1993), Hannigan (1998) defines it as a "constellation of characteristics each of which has been a reaction against the characteristics of the traditional mode of administration." It constitutes the second mode of regulation to which doctors have been the subject, and is discussed by reference to the approaches taken by both the Conservative and New Labour governments, respectively.

New Public Management and the Conservative governments, 1979-1997

In light of the escalating costs of health-care (Farnham and Horton 1993), the Conservative government commissioned an inquiry led by Roy Griffiths to evaluate the organisational regime of the hospitals in England and Wales (Griffiths 1983). The report specifically identified the absence of a clearly defined general management function and a lack of accountability as the main weaknesses of the NHS, and recommended that these functions should be vested in one person (at each level) who would take personal responsibility for securing action:

> Absence of this general management support means that there is no driving force seeking and accepting direct and personal responsibility for developing management plans, securing their implementation and monitoring actual achievement.
>
> Griffiths Report 1983: 12.

The recommended structure would introduce a continual search for change and cost improvement, motivate staff and develop a more dynamic management approach. At the same time, the report stated that hospital doctors "must accept the management responsibility which goes with clinical freedom" (p. 18) and participate fully in decisions about priorities. Up until then, the burdens for both and delivering and rationing the healthcare system were entrusted with doctors instead of politicians, policymakers, planners or managers. Their clinical autonomy underpinned such decisions as to which patients they should accept, how to investigate and treat them, whether to admit them to hospital, and how long to keep them there. Such choices were conceived as part of their everyday work. It also meant that evaluations of the pattern of resource distribution or of the quality, effectiveness and efficiency of the service were carried out by themselves.

Preceding the Conservative's intervention, managers, or 'administrators' as they were then more commonly known, helped to provide and organise the facilities and resources for medical professionals to get on with their work, and mediated conflicts within the organisation. As far as professional autonomy was concerned, the administrators facilitated the operation of the NHS without impinging on the everyday clinical activities undertaken by doctors. Despite the widespread inconsistencies in the delivery of health care and its lack of rationalisation under the self-regulatory approach, the system 'worked' owing to the agreement between parties to work: there was a very effective division of labour between doctors and nurses and, at the organisation level, little controversy about the way health care should be organised (Kirkpatrick *et al.* 2005). However, the apparent limitations detailed above in relation to NHS expenditure, together with a new-right ideology shaped by business and competitive models, meant that workplace relations would have to change.

The recommendations of the Griffiths Report paved significant inroads into the system of healthcare provision and its regulation. In spite of the BMA's opposition, which centred around the state's challenge to clinical autonomy (Kendall *et al.* 1996), the government endorsed the recommendations (Ham 1992) and appointed general managers at regional, district and unit levels of organisation by the end of 1985. The posts were open to NHS managers of all disciplines, to doctors, and to persons from outside the Service. More than 60 per cent of posts in the first round were allocated internally to former administrators and treasurers; only 12 percent went to NHS 'outsiders' (Harrison and Pollitt 1994). Many of those appointed were clinicians who undertook a part-time management role at unit level. The initial changes were therefore minimal, and the impact on curbing professional autonomy was not as marked as originally anticipated (Ham 1992; Flynn 1993; Ham 2004).

Clinical directors usually comprised consultant medical staff who continued to undertake part-time clinical work, were also appointed as members of the management board to determine unit plans, budget plans and priorities. They thus constituted two roles comprising a bureaucratic mode whilst also leading their medical colleagues. The dual expertise that was required paradoxically fuelled their authority by bridging the gap between both clinical and corporate decision-making processes, thereby challenging managerial authority (Thorne 2002). The vast majority, however, had no (and continue to be deprived of) management training (Buchanan *et al.* 1997; Newman *et al.* 1996), and were not particularly interested in

administrative issues, such as setting priorities and rationing health-care resources. This was perceived as being at odds with their historically professional prerogatives of discretion, judgment and expert medical knowledge (Hunter 1994; Buchanan *et al.* 1997; Beardwood 1999; Flynn 1999). Others, such as Swick (2001) and Thorne (2002), take the view that in the present health system, the boundaries between business and professional values are, at the best, blurred.

Managerialism is perceived as a direct attempt to limit self-regulation and to extend central government control over the profession (Hoggett 1996), which has consequently impinged on doctors' discretion and capacity to control the terms of their work (Freidson 1994). Some commentators argue that doctors' participation in hospital management as clinical and medical directors was (and remains) an attempt to shape the implementation of managerial strategies according to the interests of their profession (Gorissen *et al.* 2005; Hoggett 1996) in light of their challenged autonomy (Exworthy and Halford 1999). Applying for posts combining both managerial and clinical facets therefore prevents an erosion of discretion by managers (Hunter 1992) and retains doctors' professional identity:

> clinical directors can challenge managerial domination by combining material and medical expertise to extend their jurisdiction beyond the clinical domain into the newly defined corporate organisation. Their strategy is both a defensive device to challenge management's legitimacy for control over the organisation and part of a longer-term strategy to contest managerial organisation through new forms of workplace organisation.
>
> Thorpe 2002: 67.

Conversely, collaboration between managers and professionals was (and also arguably remains) a way for the former to keep checks and balances on the work carried out by doctors (Gorissen *et al.* 2005; Harrison 1999a; Thorne 2002). The outcome is a 'scientific-bureaucratic medicine'. It is 'scientific' in the sense that its prescriptions for treatment are drawn from an externally-generated body of research knowledge, and 'bureaucratic' in the sense that it is implemented through bureaucratic rules (albeit of a very specialised kind), namely clinical and non-clinical guidelines (Harrison and Ahmad 2000). Whereas doctors are seen as contributing a valuable clinical-scientific perspective (Buchanan *et al.* 1997), the overall medico-managerial relationship is one comprising both tension and co-operation.

In line with other public sectors such as the civil service, local education authorities, the police and local government, the ascendancy of managerialism in the NHS progressed with the first national set of performance indicators in 1983, which encouraged health authorities to experiment with managing budgets. The initial 70 indicators permitted health authorities to compare their performance, which related mainly to the use of clinical facilities within broad speciality groups, rather than to the outcomes of treatment. They consisted primarily of efficiency measures such as average length of hospital stay, throughput of patients per bed, and the intervals between cases occupying a bed, all of which represented the government's attempt to rationalise the NHS as part of its broader ideology of applying a business-like approach to the delivery of health care:

> The job for many general managers has been essentially to get more patients through fewer beds at lower unit costs, not to improve the quality of medicine or to track down those in need who may not be receiving adequate treatment.
>
> Pollitt 1993: 68-69.

In addition to the curtailing of doctors' discretion by making the delivery of health care more transparent, the ambiguities of certain performance indicators together with their doubted accuracy attracted criticisms from the professionals whose work was scrutinised (Harrison and Pollitt 1994; Fortser *et al.* 1986). They were subsequently revised in 1985, accompanied by more user-friendly packages, though this did not allay professional opposition who saw auditing practices as an attempt to gain control over their work (Thorne 2002).

Modelled on the state's ideology to replicate private models in the NHS as a means of reducing costs and raising revenues (Kendall *et al.* 1996), other key post-Griffiths management changes introduced in the NHS included mandatory competitive tendering for cleaning, laundry and catering services from outside contractors for English and Welsh health authorities. It was estimated that the first round of competitive tendering achieved annual savings of £110 million, with most deriving from contracts won in-house by health authority staff (Ham 2004). In 1984, the Department of Health and Social Services required every district health authority to include a cost-improvement programme within its short-term plan. Annual performance reviews were introduced in 1986, and individual performance reviews and performance-related pay for general managers in 1987.

A variety of factors in the latter period of the 1980s prompted the state to consider alternative emphases on its approach to new public management. Such factors included the health workforce's widespread criticism of the government in the wake of its reduced job security among certain sectors, pay and conditions, and the evolving business-like culture permeating the NHS (Kendall *et al.* 1996; Ham 2004). Matters were not improved by the government's stance against public service unions during major strike actions (Harrison and Pollitt 1994) and legislation that progressively restricted the freedoms hitherto enjoyed by trade unions (Smith and Morton 2001b). Set against this backdrop was a management culture exercising increased control over staff, their work and costs. Amid such criticisms voiced by both the public and the media surrounding the resource shortages in various parts of the NHS and long waiting lists, the Prime Minister announced a review of the Service in January 1988. This was conducted confidentially by a small group of ministers and chaired by Margaret Thatcher herself.

Its publication a year later, *Working for Patients* (1989) included proposals to allow NHS Trusts to apply to the Secretary of State for self-governing status. If granted it would enable a hospital to own its estate and manage its own budgets, in addition to regulating the pay and conditions of its staff, including doctors. Each medical consultant, for example, would receive a more detailed, locally-negotiated job description than had been customary in the past. Doctors would therefore be more accountable for their performance, their supervision increased and working autonomy diminished (Ham 1992; Foster and Wilding 2000) in exchange for increased managerial influence:

> It is unacceptable for local management to have little authority or influence over those who are in practice responsible for committing most of the hospital service's resources. The key to local management of consultants' contracts is that every consultant should have a fuller job description than is commonly the case at present. These job descriptions will be reviewed annually
>
> Department of Health 1989: 42.

While only 57 NHS Trusts came into operation on 1 April 1991, by 1996 over 450 provider units had Trust status – representing almost 100 per cent of the NHS's activities – over four phased waves of applications (Kendall *et al.* 1996). The hospitals which did not immediately

receive self-governing status had to compete for patients by separating their 'providing' role from the 'purchasing' role of health authorities. The latter would let contracts for specific volumes of particular services, and hospitals would make priced bids for these. Similarly, GPs were offered the possibility to become fund-holders, thereby controlling the budget they had to purchase elective surgery, outpatient consultations, community care and pathology.

Working for Patients also proposed the extension of arrangements for medical and value-for-money audit as a routine part of clinical work in both general practice and hospitals, and the further involvement of doctors and nurses in management through an extension of the resource-management initiative. The Department of Health put aside £3 million to fund some 360 senior hospital consultants on regional management-development programmes, which included attendance at business school, to remedy their paucity of management training. There remains little training available for those pursuing a managerial post today (Buchanan, *et al.* 1997), despite a keenness among junior doctors to apply for such posts in their more senior years (Newman *et al.* 1996). The only managerial aspects of their work were limited to leading medical firms (Dawson *et al.* 1995). It has therefore been argued that doctors lack essential management skills (Hadley and Forster 1995).

More consultant appointments were to be made available in order to reduce waiting times and improve appointment systems, and new procedures were introduced for hospital doctors to enable disciplinary matters to be dealt with expeditiously. The paper also recommended the creation of two new centralised bodies: a policy board to determine strategy, objectives and finances of the NHS, and a management executive to deal with all operational matters, including monitoring, and thereby strengthening management arrangements. In line with this trend, the ascendancy of new public management has led many authors to conclude that medical dominance has reduced in line with their autonomy and self-regulation (Williams 2001; Harrison and Ahmad 2000; Hoggett 1996):

> The corollary is that the power of even the most well-placed pressure groups may not always be sufficient to defeat proposals put forward by ministers. This lesson emerges from the failure of the BMA and other groups to stop the government proceeding with the implementation of *Working for Patients*
>
> Ham 2004: 49.

The state's challenge to professional autonomy was not only demonstrated by its decision to implement the recommendations in the face of such opposition (not least from the BMA which argued against the introduction of market principles in health care (Ham 1994)), but also by the Conservative's departure from the established consultative process by excluding such pressure groups as the BMA (Harrison and Wood 1999a).

The end result was the NHS Community Care Act 1990. Responsibility for overseeing the implementation of the reforms was vested in the NHS management executive working on behalf of ministers. The cornerstone of the legislation was its concept of the internal market, constructed to ensure competition based on valid information and minimal transaction costs (Dent 2003). It involved the separation of NHS functions into both 'purchasers' (District Health Authorities and those general practices with practice budgets) and 'providers' (hospitals, clinics, community services, etc.). Previously, Health Authorities assumed the responsibilities of both purchasing and providing health services. The purchasing agencies introduced by the legislation were responsible for holding a budget to ensure the health of a defined population, of identifying health needs, for planning ways to satisfy them and ensuring the quality of the service, and for developing contracts with providers. They would, in turn, invoice the purchaser for the care provided. The internal market was designed that money would follow the patient and that there would be an incentive for providers to attract customers, to increase productivity and standards, and to look for ways of ensuring that they won and maintained better value contracts.

As with the content and implementation of the Griffiths Report (1983) the BMA was again marginalised in the preparation, consultation and delivery of *Working for Patients*. Its role presented a stark contrast to the professional-state co-operation in the formation of the NHS in 1948 and the earlier 1911 National Insurance legislation. Such trends reflected the broader declining relationship between the state and trade unions as the Thatcher government departed from the corporatist tendencies of previous administrations and reasserted the role of government itself in policy-making (Ham 2004) and, in so doing, unsettled established relationships between the Department of Health and organisations such as the BMA. Together with the twin creations of the internal market and self-governing NHS Trusts by the 1990 NHS and Community Care Act, the legislation's attempt to decentralise the onus of 'employing', and hence determining pay and the other working conditions, of NHS staff to managers of the individual trusts fuelled union hostility:

> The attempt to move to local pay and the continuing uncertainty over the locus of determination of NHS workers' terms and conditions represents one of the most swingeing changes since the service was established in 1948, and constitutes an ongoing and immediate challenge to employee representative organisations.
>
> Thornley 1998: 418.

Trade unions in the NHS have traditionally endeavoured to maximise their influence on industrial relations at the national level as this was the locus of power and influence. The centralised nature of the Service is characterised by the extent to which policy-making authority is concentrated at national level rather than regional or local levels (Bach 2004) (though regional devolution has had an impact). Pay and conditions were previously determined by centralised pay bargaining with little involvement by local management or employees. With the exception of medical and nursing staff and those working in the related professions, the pay and conditions of NHS staff were dealt with through a series of national negotiating bodies known as the Whitley system. 'Whitleyism' represents a highly formalised system of bargaining, consultation and dispute resolution, based on codified procedural arrangements and a formally constituted, hierarchical machinery, which became characteristic of the public sector (see Clay 1929). The first Whitley Councils were aimed at making and considering suggestions for securing permanent improvement in relations between employers and workers. Before them, public sector pay was determined by inquiries and commissions (Prowse and Prowse 2007). Whitley Councils were established as consultative mechanisms for joint industrial councils, civil service staff associations and managers at national level. They were devolved from ministerial and departmental level, to regional and local level, and their principles were extended across the public services, including health in 1949. Employers were encouraged to recognise trade union membership and it made the state accountable to the public for decisions on management, recruitment and rewarding staff. In this respect, public sector industrial relations were, at the time, more regulated than their voluntarist private sector counterparts (Prowse and Prowse 2007).

Medical and nursing staff and those in the related professions had their pay determined by the government after the recommendations of national pay review bodies (their other terms and conditions were determined by centralised collective bargaining in the Whitley machinery). The medical profession's remuneration was, and continues to be, centrally determined by the

Review Body on Doctors' and Dentists' Remuneration (DDRB). Its role is to make recommendations to the Prime Minister, the Secretary of State for Health, the Secretary of State for Scotland and the Secretary of State for Wales on the remuneration of doctors and dentists taking any part in the National Health Service (DDRB 2006). Its impartiality is consistent with the principles of the NHS for doctors to be distributed evenly both geographically and by specialty. The independent nature of the DDRB is seen as ensuring that doctors' pay is not vulnerable to government economic policy (BMA 2004a). Any significant move towards local pay determination has been rejected as potentially undermining this important benefit to patient care. Junior doctors' pay, after the 1990 Act, continues to be determined in such fashion. For these reasons, all the professional organisations apart from the BMA and the Royal College of Nursing have been squeezed out at the level of local determination. The BMA and RCN have therefore been well-placed to have a powerful influence on industrial relations in NHS trusts (Bryson *et al.* 1995).

The 1990 Act's shift from national to local bargaining challenged trade unions by creating a system of pay determination at Trust level, with or without union involvement and irrespective of NHS national agreements. Farnham and Horton (1996) argue that such changes in public sector management during the 1980s and the adoption of private sector management techniques have transformed the public sector. New local management arrangements represented a "deliberate attempt to reduce the personal discretion which individual clinicians have by exerting budgetary controls on them", all of which had a knock-on effect on staff morale and "debilitating reorganisation exhaustion" (Bradshaw 2001: 311). This fitted with the Conservative government's overall industrial relations objective throughout the public sector. These were to decentralise pay determination from the multi-employer, national level to the single employer at a local level so that labour-market conditions could be better reflected; to empower local managers so that they could become operators rather than administrators; to devolve decision-making to levels where the public sector unions traditionally had been weaker; and to change organisational culture so that greater priority was given to the needs of customers rather than producers (Corby 1992).

The arrival of the Conservative administration in 1979 and its perception of collective laissez-faire marked a fundamental change in the philosophical underpinnings of industrial relations policy and the direction of legislative change. Collective bargaining was now viewed sceptically by the state, as a potential impediment to the efficient allocation of labour

and a contributing factor in high inflation. The neoliberal economic arguments all pointed to the same direction. They called for a change in the law so as to limit the power and influence of trade unions, at the same time as removing what the government called 'obstacles' to the creation of jobs in the form of statutory regulation of terms and conditions of employment (Deakin and Wilkinson 2005). Deregulation was seen as removing regulatory rigidities, and would free up the labour market to operate in such a way as to maximise efficiency and preserve effective competition. Among other things, trade dispute immunities were cut back, thereby inviting the courts back into the control of industrial disputes; new statutory procedures were put in place to govern the conduct of strikes and legal support for the closed shop was removed (Smith and Morton 2001b). The end result was an individualism paralleled with the form of regulation which characterised the pre-nineteenth century master-and-servant relationship. Decentralisation and the absence of minimum legislative standards threatened the long-term viability of collective bargaining.

Conservative policy was one influential factor which has been associated with the reduction in the influence of multi-employer, sector bargaining, and a fall in the coverage of collective agreements and other forms of wage determination. Paradoxically, the employment contract became more standardised at enterprise level despite the decentralisation and privatisation of services (Deakin 1999). In both unionised and deunionised firms, the contractual terms of the employment relationship took shape as a standard form agreement largely set by employers.

Deakin and Wilkinson (2005) argue that labour regulation raises issues surrounding its capacity to deliver solutions which are compatible with the preservation of market order. Deregulation and market order are necessary conditions for the freedom of individual members to pursue their work in such a way which precludes the imposition of purposeful and monolithic 'public laws' – such as equality clauses contained in the equal pay, discrimination, minimum wage and even working time legislation – that are superimposed on the contract of employment. They cite arguments which claim that social legislation is contrary to both efficiency and justice, and produce conceptual confusions as a result. The contract of employment is separated out from the general law of contract, with the aim of subjecting it to special rules whose principal purposes include the protection of employees. However, such regulatory legislation, despite its tension with the historical forms of governance under which British industrial relations have developed, provides a means of

addressing employers' attempts at evading protective ideals shaped by welfarist legislation (Deakin 2000).

In August 1994, the government gave further impetus to local pay determination and, with the support of the chief executive of the NHS, requested all trusts to prepare action plans by October 1994 in order to have local pay machinery set up by February 1995. Union response was again exceptional and hostile (Thornley 1998). The RCN voted to allow limited industrial action by amending its 79-year old rule forbidding it. The BMA, although unaffected by the proposition, lent its support to the campaign for the retention (and improvement) of national machinery. The dispute was narrowly avoided by a framework agreement providing for a protective uprating mechanism, whereby minimum pay rates would be guaranteed even in those trusts where local pay agreements or impositions had been below the national average. Any Trust that had awarded less than a nationally agreed amount had to make it up in the next year's increase.

How did both unions and NHS management respond to the devolved powers under the 1990 Act? The problem with investigating many areas of the public service sector, including the NHS, is that traditionally few decisions have been made locally, and therefore it is difficult to assess the changing influence of trade unions over managerial decision-making (Lloyd 1997). Studies, however, have generally depicted that early progress towards local pay arrangements and union recognition was slow and inconsistent (Carr 1999; Thornley 1998; Lloyd 1997; Bryson *et al.* 1995; Corby 1992). This variation was reflected within the wider labour market (Deakin 1999). Trade union recognition is a crucial issue for Trusts intending to introduce local pay bargaining. Some studies reported delays and a lack of provision of basic information by managers to all negotiating parties; and that decentralising collective bargaining in the NHS had increased the potential for conflict between unions and NHS management (Thornley 1998). Not all staff organisations were permitted at the main bargaining table (Corby 1992). Such initiatives as new job-evaluated pay structures were introduced among some Trusts together with single pay spines and performance-related pay. These broke down job demarcations in the interests of flexibility, and harmonisation of conditions. Skill mixing or reprofiling the workforce offered management a tool to substantially reduce staff costs and to escape the rigidities of job and grading structures. The new contracts of employment were vague about pay and reserved considerable discretion to employers (Deakin 1999). There was also a move towards revised grievance and discipline

procedures, some of which were stricter than the existing arrangements. Changes in non-pay terms were driven by management goals of rationalisation and harmonisation, all of which diminished the union role of joint regulation. There was simply less opportunity for the unions to get involved:

> These moves have weakened the ability of unions to help members in both individual and collective matters, by enabling local managers to the final arbiters and by removing access to impartial justice.
>
> Bryson *et al.* 1995: 128.

Such developments could be achieved independent of union action. It therefore comes as no surprise that the trade unions, particularly those affiliated to the TUC, were hostile to the establishment of both trusts and local bargaining which –

> Served to shift the balance of power away from the unions and underline the message that the unions could not count on playing a part in determining pay.
>
> Corby 1992: 39.

By contrast, Carr (1999), Lloyd (1997) and Bryson *et al.* (1995) found that the majority – but not all – of the Trusts in their samples had agreed to recognition procedures, which were matched by an overall increase in both bargaining and consultation. Managers had also reported that they were providing more financial and operational information to staff than in the past, and that the process of local talks had increased the flow of information. There was no evidence of the information being used to undermine unions and the main objective was to draw attention to what was affordable in negotiations. A proportion of managers were seen as giving a strong commitment to working with unions. In pragmatic terms, constructive industrial relations were seen as a key factor in securing early union recognition and employee management during a period of immense organisational change. Trust status had, at times, provided the impetus for more workplace activity and improved inter-union organisation (Lloyd 1997). Hutchinson (1994) similarly found that new recognition agreements with trade unions had been reached by 60 percent of Trusts, though in most cases Trusts had simply continued to recognise all those unions they previously dealt with.

Amid the more fragmented NHS that resulted from the establishment of separate Trusts, Bach (2004) argues that the state retained a tight grip on the Service by ensuring that the Secretary of State for Health remained responsible for the policies and administration of the NHS overall. More auditing of outcomes was also instigated, thus making certain that formal devolution of managerial authority to Trusts did not weaken political control. Consequently the establishment of performance indicators, broadening the remit of the Audit Commission to include the NHS and other audit processes, such as medical audit, proliferated under successive Conservative governments.

New Public Management and New Labour

The election of New Labour in 1997 signified a different agenda with increased investment in the public sector, union recognition and partnerships, although the government did not reverse any privatisation policies, except for the rail industry (Prowse and Prowse 2007). The government endorsed labour-management cooperation and 'partnership' as an effective approach for improving economic performance:

> In paving the way for the new NHS the Government is committed to building on what has worked but discarding what has failed. There will be no return to the old centralised common and control system of the 1970s. But nor will there be a continuation of the divisive internal market system of the 1990s. Instead there will be a 'third way' of running the NHS – a system based on partnership and driven by performance.
>
> *The New NHS* 1997: 10.

Policy under New Labour shifted towards voluntary understanding and cooperation whilst considering the prosperity of both the employer and employee. A major shift in legal policy occurred with the enactment, as part of the Employment Relations Act 1999, of a statutory procedure under which an independent trade union may establish a legal right to recognition for the purposes of collective bargaining. Parliament also passed the National Minimum Wage (NMW) Act 1998 and implemented the European Working Time Directive 1998, although in relation to the latter "it is unclear whether the relevant steps would have been taken had it not been for pressure from the European Community" (Deakin and Wilkinson 2005: 339; Smith and Morton 2001a).

Neither of these measures, however, represents a complete departure from the deregulatory policy of the preceding Conservative government. For example, the Directive has been implemented in such a way that takes full advantage of the legislation's derogations, which severely dilutes the Regulations' overall impact. Its minimal effect is indicated by the little it has done to discourage the systematic use of overtime working (Arrowsmith 2002). Nor has it been used, as it might have been, to promote more effective employee representation. Some of the Regulations' provisions can be varied by collective agreement at sector level or by agreement between the employer and trade unions or enterprise committees at workplace or company level, however there is little evidence of these collective channels being utilised (Barnard *et al.* 2003). Collective bargaining and social legislation are still seen as separate forms of labour-market regulation, rather than as being potentially complementary.

In the English NHS, primary care Trusts were established in 1999 and they were given full responsibility for primary care and community health services, and services for people with mental illness and learning disabilities. New inspection and audit regimes have been introduced, and New Labour has extended Conservative policy by the proliferation of new targets and performance indicators (Kirkpatrick *et al.* 2005; Prowse and Prowse 2007). During its term in opposition, New Labour accepted the value of the separation of purchaser and provider responsibilities, but has, since assuming office, discouraged competition between Trusts in favour of more co-operative agreements. Its approach was to foster competition among hospitals to achieve better quality than for funding purposes. Despite the continuity between the two governments' agenda of bolstering centralised systems of performance management, then, the ideology underpinning that agenda differed significantly (Kirkpatrick *et al.* 2005; Bach 2002). Whereas the rationale underlying Conservative policy was to structure the NHS on a business-like model that aimed to promote efficiency and competition, New Labour based its organisation of health care as a means of ensuring that providers were held to account for their performance (*Renewing the NHS* Labour Party 1995). Among the NHS's structural reorganisation, health authority purchasers were replaced by primary care groups, and primary care Trusts were established. Health authorities were reduced in number, and general priority was afforded to primary care and general practice over secondary care, with the intention of enhancing the Service's responsiveness to patients' needs (*The New NHS: Modern – Dependable* 1999). These changes introduced a notion of subsidiarity into the system with decisions being made at a local level, though the reforms themselves were centrally directed rather than a response to local demands (Dent 2003).

Its report, *Delivering the NHS Plan*, issued in April 2002 at the same time as the budget, described a new emphasis on patient choice and the commitment to develop greater plurality of provision. As part of the strategy to attain these aims, it included commitments to maximise the use of spare capacity in private hospitals, bring in overseas clinical teams to establish services for the NHS, and to develop new public-private partnerships to support the rapid development of diagnostic and treatment centres. The NHS, however, firmly remains a public sector entity, with only 13% of orthodox medical treatments being supplied by the private sector (Fox 2007).

Proposals to establish NHS Foundation Trusts were consistent with the policy of developing greater plurality of provision. Top-performing hospital trusts could now apply for foundation status and function as independent bodies in which local public accountability replaces central state control. They have increased freedom to retain operating surpluses and to access a wider range of options for capital funding to invest in the delivery of new services. Each Trust is able to raise and expend funds in accordance with the priorities of governing bodies comprised of health service providers and residents of the area it serves. They recruit and employ their own staff and, although they must deliver on national targets and standards like the rest of the NHS, they are free to decide on strategies to achieve this, and are not subject to direction by the Department of Health. Foundation Trusts, however, have come under severe criticism for their possibility of creating a two-tier health system (Klein 2002), particularly as the budgets and performance of those hospitals that do not 'earn' foundation are more tightly scrutinised by the Department of Health.

Taken together, the policies set out in *Delivering the NHS Plan* are therefore similar in a number of respects to those that regulated the internal market under the Conservatives. This was particularly apparent in the emphasis placed on patient choice, the system of payment by results in which money would follow patients to providers, and the commitment to establish NHS Foundation Trusts (Ham 2004). As in the 1990s, these policies were intended to create stronger incentives to improve performance and to ensure that the NHS really did work for patients. A further similarity between the two governments has been the willingness to use the private sector to develop new forms of public-private partnerships. The approach in *Delivering the NHS Plan* in this area signalled a marked departure from New Labour's early

period in office when the NHS was actively discouraged from working with the private sector.

Devolution and the NHS

The policies outlined above have not been adopted consistently among the other three nations, particularly in the wake of political devolution in 1998. The financial arrangements for the UK NHS continue to be determined by the UK Treasury. UK government spending reviews, which take place every two years and cover a three-year cycle, determine the amount of public expenditure available for Wales, and the devolved governments then decide how this sum should be allocated among its departments. However, the separate administrative structures in the four nations have accentuated some of the different health policies and processes in Britain. Each nation has attempted to create a service that is sustainable within the current funding infrastructure. The consistency between the various systems are further complicated by the nationalist-unionist debates particularly in Scotland and Wales which need to show that they are "not blindly obeying London, and avoiding policies labelled English" (Greer 2005c: 100). This marks a difference from the close ties between the Welsh Office and Whitehall before devolution.

England is clearly adopting a competition model which entails increased involvement of the independent healthcare sector, and using market style incentives to create a self improving system, thus echoing the Griffiths reforms of 1983 and the internal market formulated and implemented by the previous Conservative government in 1991 (Ham 2004). The English policy aims to expose the NHS to patient pressure by forcing providers to compete for referrals, based on the view that a more responsive, 'patient centred' service will result. Policy priorities now include developing more points of treatment and better information to judge services, which will both aid consumer-style choice, including the government's effort to address waiting times. On the one hand, the English health policy community is unique in nurturing many more pro-market, pro-management ideas than any other in the UK (BMA 2007b). On the other, the devolved nations are largely addressing problems through service redesign and rationalisation as opposed to using market-based models.

Regulatory agencies ensure that competition does not produce problems. The Healthcare Commission, for example, regulates quality, a special regulator for the finances of the

foundation hospitals demands that they balance their budgets, and NICE evaluates technologies. The Government is also introducing Payment by Results (PbR) as an accounting device by fixing a tariff for each procedure, with the intention of identifying costs and inefficiencies (Greer 2005c).

The NHS Reform (Scotland) Act 2004 gave Scotland a legislative framework to implement its professionally led single system working through Community Health Partnerships, focusing on networked clinical management. Policymaking including rationing and resource allocation is now led by medical and professional elites, with a noticeably phased reduction of managerial layers which were implemented in light of the internal market. It has regionalised its organisational environment through the creation of fifteen health boards working also with local authorities. It has sought to centralise the most complex high-end services, but has generally moved care out into the community to community treatment centres and the primary care sector. The 'single system' replaces purchaser-provider split, and trusts have been dissolved. On a smaller scale to England, Scotland has used private sector capacity to improve facilities, but this is not a significant policy drive. Rather, in Scotland the focus is currently on the use of networks and professional partnerships to deliver the service. Whereas in England the focus is on market forces and associated financial incentives to provide efficient services through competition and a separation of commissioning and provision. Scotland, on the other hand, is forging united health systems breaking down these structural barriers.

The elections in May 1999 led to the creation of a 60-member Assembly in Wales. While the Westminster Parliament retained power over the constitution, defence, the economy and other major areas, devolution gave Welsh government control over areas such as health and social care. Wales was also given a new political figurehead for its NHS; prior to devolution, the Secretary for State for Wales assumed the role, but after 1999 responsibility shifted to the Minister for Health and Social Services in the Welsh Assembly Government (Sullivan 2007). The role is supported by the Director of NHS Wales and is held to account by the Health and Social Services Committee of the Assembly.

The Welsh government produced its own version of *The NHS Plan – NHS Wales: Putting Patients First* (1998). It proposed the establishment of local health groups instead of primary care groups as was recommended in England. These were set up in 1999 on a conterminous basis with local authorities and as subcommittees of health authorities, bringing together GPs, other primary care contractors, health professionals such as nurses and other local interests. It also abolished GP fundholding in Wales.

NHS Wales has continued to operate on a similar basis as it did pre-devolution however there is no longer a reliance on political direction from the centre. Power is now concentrated into twenty-two local health boards (LHBs) in each of the local authority areas, which replace Local Health Groups, and focus on local issues (there are 14 NHS Trusts in Wales and they manage about a hundred and thirty-five hospitals), reporting to the National Assembly of Wales. With technical advice from the centre and three regional offices, the LHBs commission services from trusts in line with local priorities and demands.

As a result, there is a considerable emphasis on local NHS bodies and local authorities working together to meet local needs. This has in some respects resulted in less capacity to make all-Wales decisions (Sullivan 2005). The fragmented nature of localism has also limited the power of health boards to shape large and powerful acute trusts. The Wanless report (2003) found that there was an unacceptable variance in performance between NHS Trusts and primary care and that there has been repeated overspends in the NHS in Wales.

Wales has less input from the private sector than other devolved nations, and there are no clear organisational plans to implement this using professional elites, which distinctly contrasts with England's and Scotland's policies. Like Scotland, the public health agenda in Wales is predominantly focused on reducing inequalities and preventing ill health (Wanless 2003). Policymakers have adjusted the way resources are allocated in the NHS to take account of the needs of disadvantaged areas and created an 'inequalities in health fund'. The NHS therefore serves to improve the population health rather than the concern in England to implement targets for individual patient care. Furthermore, the latter approach emphasises the

individual as a consumer in a market-orientated system, as opposed to Wales' focus on the individual as citizen (Sullivan 2005.)

There are, however, some similarities between the way that the NHS operates in both England and Wales. Perhaps most importantly, they include the principle of universal access and equality of care across the Principality, in a patient-centred Health Service. Just as in England, the NHS in Wales has national targets that it must achieve, including shorter waiting lists for GPs, dental treatment and Accident and Emergency admission, better health promotion strategy, and improved access to clinics dealing with sexually transmitted diseases and contraception, cancer services and services for the elderly and young (*Designed for Life* 2005a). It has also implemented transparent corporate and clinical governance throughout the organisation.

Furthermore, there are also a number of shared organisations between England and Wales. These include the National Institute of Clinical Excellence (NICE), The Commission for HealthCare Audit and Inspection (CHAI) and the NHS Executive. The Minister for Health and Social Care also sits on the Joint Ministerial Committee (JMC), alongside the Health Ministers for England, Scotland and Northern Ireland. Regulation of the healthcare profession is also UK-wide with professionals in each nation adhering to the same framework.

In light of the differences which exist between the devolved authorities, Greer (2005c) argues that two factors pose significant threats to the system which could further lead to tensions. The first relates to the political context. Thus far, the presence of a majority of Labour representation in each devolved government has been able to minimise conflict. It is unclear how the system will be affected with shifts in power between political parties, the most recent being the success of the SNP in the Scottish elections. The second threat comes from Europe. EU policy-making does not take into account the views held by devolved governments; such governments are not invited to EU councils, and cannot vote. The EWTD is a good an example of this, illustrating the lack of autonomy and authority of devolved nations over such supranational policy. This forms the basis of discussion in the next section.

Before considering the impact of statutory control and the impact of European policymaking on national governments, it is important to discuss another aspect of NPM; that is, the attempt

by policymakers in the UK to deliver a better quality of care in the NHS. This does not fall within the ambit of employment relations which forms a core theme of the present study, though a brief discussion is critical in our understanding of the state's continued attempt to regulate the medical profession with little consultation (Som 2005), and the latter's response to its adjusting clinical autonomy. In so doing, it highlights the objectives which the managerial reforms failed to achieve during the years preceding the New Labour government.

Debates bringing together standards of quality with performance management revolve around the concept of clinical governance – a "corporate accountability for clinical practice" (Taylor 2002: 65). These principles, among others, were documented in *The New NHS* (1997). New Labour explicitly recognised continuity between both government policies, but a new emphasis on clinical governance by cooperation was to be the strategy for attaining its goal. Calls for medical regulation also stemmed from the consumerist patients who nowadays are more likely to question a doctor's judgement and seek remedies as a result of clinical errors (Forlin 2003), some of which have recently been highly publicised in the media. While the profession continues to enjoy a generally high social standing (Lupton 1997), in terms of professionalism these experiences have cast doubt on medical profession's ability to uphold its values of integrity and patient interests (Stacey 1992; Nettleton and Harding 1994; Davies 2000). The state has, in some instances, acted on these concerns by pursuing a regulatory policy for the profession, such as clinical governance and the more recent recommendations by the Chief Medical Officer in England to reform the GMC (*Good Doctors, Safer Patients*, 2006a):

> A regulatory body needs to command the support of both the public and the professions and it is government concern with repeated allegations of malpractice and its fear of loss of public confidence, which has led developments to date.
>
> Davies 2004: 58.

This process of clinical governance was facilitated by the reorganisation of the NHS in 1999, and the establishment of primary care groups. Among other changes, the number of NHS Trusts was reduced and chief executives were given statutory responsibility over clinical governance. There was a return to greater emphasis on reducing variations in performance through the development of national service frameworks and the creation of agencies such as the National Institute for Clinical Excellence (NICE). The latter's emphases on prescribing

standard guidelines, clinical audit and cost-effective treatment distinctly echo the attempts by managers during the 1980s' reorganisation of the Service but on a far broader scale, and supported by an ideology concerned with performance rather than rationalisation.

Other agencies and regulatory bodies, spanning both England and Wales, buttressing the work of NICE, include the Commission for Health Improvement (CHI) which monitors the delivery of care; the Council for the Regulation of Healthcare Excellence (CRHE), the Modernisation Agency, the National Patient Safety Agency, and the National Clinical Assessment Authority (Wales also boasts its Healthcare Inspectorate Wales, launched in 2004, to monitor, review, and investigate standards in Welsh NHS bodies) . Such "layers of bureaucracy over already difficult, cumbersome and sometimes lengthy procedures" (Jolly 2001: 1095) are in addition to the existing NHS regulators, including the Audit Commission, National Audit Office, the Health and Safety Executive, the Equal Opportunities Commission, the Data Protection Registrar, the Mental Health Commission and the Health Service Commission, resulting in a highly fragmented "mosaic of regulatory arrangements" (Walshe 2002: 968). The managerial presence continues to dominate discussions surrounding the reorganisation of health care provision in Britain. The perpetual regulation – albeit a mix of both clinical and administrative form – has served to further scrutinise the work of doctors, and to put pressure on them to change their activities in ways that managers themselves cannot undertake, through such initiatives as audit and league tables (Kirkpatrick *et al.* 2005). As such, these debates acknowledge the inadequacy of the latter's authority which explains to a good degree the incorporation of clinical professionals in managerial jurisdictions.

The significance of these initiatives lays in recognition that self-regulation by the health professions was no longer sufficient to ensure consistently high standards, and that new mechanisms were needed to promote quality within the NHS (Ham 2004). It also suggests that the new public management programme has not succeeded to achieve the aims it initially purported to address. New Labour's attempts to continue on the quest of regulating doctors represent the broader effort of standardising the medical professions' working relations, where previous administrations – as far back as the passing of the National Insurance Act 1911 and the National Health Service legislation in 1948 – have failed. This has led to the prospect of a third mode of regulation, namely statutory control. To this extent, there is a degree of overlap between NPM and legislative action insofar as some of the former's

initiatives entailing the reorganisation of the NHS and the establishment of regulatory bodies, such as the CRHE, have been implemented by Parliamentary statutes.

Statutory control

Governments and policymakers often view legal regulation as the most appropriate, independent and publicly accountable way of controlling certain aspects of professional work. For example, the legislation surrounding medically assisted reproduction and experimentation on human embryo fertilisation is perceived as an instrument that is able to incorporate the varying concerns of religious organisations, feminist groups, right-to-life movements, the medical profession, and the patients (Anleu 2001). It can constitute and define the boundaries of medicine, and draw up the limits on clinical autonomy.

By convention, the state has largely "steered clear of changes to [medical] regulatory legislation, whether for fear of respect for the profession or because of more pressing issues of legislating directly for services" (Davies 2004: 56). Baldwin *et al.* (1998) suggest that both public expectations and the governments' obligation to protect the public's best interests have driven the state's recent interventionist trends. Initiated by the Conservatives, New Labour has progressively intervened in its approach to both clinical and financial regulation on the medical profession because the latter has failed to strike a balance between the demand for, and supply of, health-care, nor has it delivered care to a standard the policymakers regard as acceptable (Hood *et al.* 2000; Williams 2001; Salter 2002). It is therefore the profession's own failures which have led to the circumstances that have steered the state's regulatory vehicle (Freidson 1988).

While many of the institutions of the welfare state, including collective bargaining, have been weakened by virtue of 'flexibility' or the application of 'market forces', a new form of social rights has arisen to guarantee the effective conditions for the functioning of the modern labour market. These are social rights of the type which have been articulated in the context of the European Community which, according to the European Court of Justice, do not yield to the economic policy goal of an integrated market (Pollack 2003) Such arguments are played out in the context of the EWTD's application to the medical profession discussed in the next chapter. In this light, the European market arguably incorporates a set of core social rights that create a balance of power in the workplace as well as in the wider society. They legitimise and promote the role of trade union and collective bargaining on the one hand, and

establish legally binding minimum terms and conditions of employment, the provision of health care, education and social support, and full employment as a primary policy objective on the other (Deakin and Wilkinson 2005).

The EC presence has always featured in the UK health services and has influenced the individual worker's contract of employment by way of stipulating requirements relating to general issues as safety, labour, and non-discrimination, to the more sector-specific regulations such as medical devices and pharmaceuticals. The political challenge from the point of view of most health professions has been to maintain 'sectoral' intervention: "professions assumed that not only will general regulation respond to their individual problems but will also destabilise their presumably acceptable existing regulatory forms" (Greer 2006: 9).

More recent EC regulatory intervention, however, has impinged on the way in which both the NHS and the medical profession are organised. This stems from the overall impression taken by the European institutions – and the ECJ in particular – that such systems are essentially economic activities. They operate within capitalist economies, adjacent to markets in goods, services, and labour, and those markets are the constitutional and practical core of the Common Market (Greer 2005a), and are therefore subject to internal market legislation. The Single European Act 1986, discussed in chapter 3, established the EC's authority to legislate on issues of health policy connected with the internal market.

Some of the more controversial, yet unintended, outcomes of European single market legislation manifested in the EC health systems and their respective medical professions have involved the European Working Time Directive, the regulation of medical qualifications, and the recent ECJ rulings concerning patient mobility across different health systems. Because the EC has consistently left health services as a matter for national governments, the recent statutory controls have taken the profession by surprise:

> Few health professionals anticipated how the medical landscape would be changed by EU legislation enshrining the right of free movement of good, services, and people. Fewer stills saw the massive revolution that the '48-hour' European Working Time Directive would trigger.
>
> Richards 2007: 185.

The Directive represents an encroachment on the working relations of doctors, and which does not conform in either nature or form to the self-regulatory mode that has historically governed their profession. It goes beyond the parameters of new public management by unilaterally imposing standardised employment conditions that are supported by both civil and criminal sanctions, and without professional consultation at local levels. Outside the scope of health, the Directive represents a form of European social integration, pushed through by the EC institutions (Pollack 2003) upon an area of employment in the UK which had, up until then, no statutory restrictions on working time. The legislation embodies a third mode of regulation that is highly centralised, moving away from internal governance and national regulation to a European form of control. It follows in the wake of a general campaign by various EC bodies to regulate the working time of the European Community's workforce. Trade union movements in the UK have attempted to achieve similar entitlements through collective bargaining (chapter 3). The EWTD does not, however, address the arguments voiced within these national and professional boundaries.

In terms of industrial relations, the situation is not wholly bleak. Proposals to amend the existing EWTD provisions are designed to provide a significant regulatory stimulus for collective negotiations over innovation in working-time arrangements, pay and productivity. Collective agreements and consultation underpin certain provisions relating to the legislation's derogations. The Directive therefore demonstrates how dialogue and negotiation of employment policy and regulation can occur within the parameters of a generic piece of legislation. This could be a significant dynamic in the context of UK industrial relations given the general lack of structures promoting social dialogue in the past (Hobbs and Njoya 2005).

On a broader scale, the EC regulatory drive has enhanced the role of industrial relations actors. The implementation of recent regulations under the European Employment Framework Directive (EFD) – which addresses fuller participation in the labour market by precluding restrictions on age, religion or belief, sexual orientation or disability, and an extension of the existing sex and race discrimination provisions – promotes the role of representative bodies and unions in ensuring collective rather than individual enforcement of the right to equality. Critics of such laws argue that it should not purport to change attitudes and behaviour because attempts to do so impose unacceptable restrictions on the freedom of

contract and the inherent ability of the market to correct any inefficiencies caused by discrimination without legal intervention (Epstein 2002). Deakin (2002) argues that the reality is that market failures prevent such spontaneous adjustment from working, and therefore requires the intervention of anti-discrimination law. This is particularly the case with instances such as the removal of collective bargaining that occurred under the Conservative years and consequently gave rise to alternative sources of governance, including managerial prerogative (Deakin 1999). Others claim that such intervention can take a reflexive approach (Hobbs and Njoya 2005), not by attempting to compel people to abandon deeply ingrained prejudices, but by enforcing procedural safeguards against discriminatory treatment. In the long term, this would raise standards, encourage the development of equality norms, and enhance the creation of a fairer working environment.

One of the other relevant key freedoms enshrined in the EC is labour mobility, encapsulating freedom of movement and establishment. Such policies have as their goal make Europe one labour market, with no impediments to the rights of citizens, workers and professionals of the different countries to move back and forth to work (Greer 2005a). Directive 93/16/EEC facilitates the mutual recognition of medical qualifications across Europe, thus relinquishing some of the powers over training and licensing hitherto confined to the individual states' self-governing medical professions. The latter are consequently losing considerable control over their ability to shape their workforce (in addition to making entry into the profession more accessible (Fox 2007)).

Cross-border patient mobility has also been legitimised by the ECJ. The decisions of Kohll and Decker permitted citizens of Luxembourg to use a health service provided by another EU country, and then to seek reimbursement in Luxembourg (for details see Richards 2007). The Court ruled that this was a right under EC law. More recently, Yvonne Watts from Bedford in England had a hip replacement done in France after initially being told by the NHS that she would have to wait a year for an operation. Having asked the NHS to pay for her costs, she was refused. The ECJ ruled in her favour, deeming that a year's wait for surgery was "medically unacceptable" (Richards 2006). The rulings have underscored the right to free movement of goods, services, capital, and people, which overrides the clause (paragraph 5 of article 152) in the Treaty of Amsterdam that stipulates that the organisation and financing of health services is a national prerogative. Such decisions challenge the rationing mechanism of health policies in most countries, and have created a degree of legal uncertainty in this area

(in addition to others, such as the EWTD, for as long as the ECJ continues to exercise "piecemeal judicial health policymaking" (Greer 2006: 14).

European policy therefore poses risks for the dominant stakeholders in health policy. Health politics in the UK is usually about the contests between a few groups – the BMA, the RCN, other unions, other Royal Colleges, the NHS Confederation, and above all, the Department of Health and central government departments. The EC further complicates the picture with its proliferation of diverse lobbies and interests groups, but of particular concern to the UK representatives is their degree of influence in Europe. Unlike the historical professional/state relationship, crafted by the dominance of the former and monopolised to attain distinct advantages in the UK labour market, doctors in Britain lack such comparable deep-rooted ties with the European legislature. The BMA (since 1995) and other major health services unions have only held a presence in Brussels with full-time officers engaged in information gathering and lobbying for a relatively short period. The other Royal Colleges have invested much less. These have inevitable ramifications for their influence over policymaking. The professionals must also overcome other ingrained problems. For one, professions are so different across Europe that they have difficulty acting in unison, and most professions are so strongly tied to their governments that they enter EU politics reluctantly, badly and late (Greenwood 2003).

The 'Europeanisation' of UK health systems may also affect devolved states, such as Wales, which are in danger of losing some considerable part of their recently acquired health powers (Greer 2005b). The EC can take away or seriously dilute such regional competencies. The EWTD is the prime example of this, where ECJ rulings are impinging on the delivery of medical care and the structuring of health care systems. The complex multi-level governance is reducing the autonomy of regional governments and their ability to be accountable to their populations for what happens, and adds an extra administrative complexity. Inter-state consistency may also be jeopardised in the UK. Devolved or centrally-made decisions might satisfy some but not others, which might make foregoing a common view more difficult. Wales, however, does benefit from longstanding European connections of its health policymakers. In the mid-1980s, when health policymakers in the UK were still largely parochial, the Welsh NHS began to develop its international links and profile through connections with the EC and the creation of a cadre of officials who engaged with EC and international circles, particularly about health issues (Greer 2006).

Conclusion

This chapter has focused on the modes of regulation that have sought to govern the workplace relations in the medical profession in an attempt to illustrate three trends. First, it shows key interaction which links doctors' historical forms of control to the concept of professionalism. Secondly, it has documented the evolving nature of state intervention on a profession hitherto regulated by its own internal mechanisms, and the reasons for doing so. These have been contextualised by discussions on the broader trends in employment relations. Thirdly, it has demonstrated the profession's response towards its three central modes of regulation, all of which retain a simultaneous relevance to a varying extent.

Attempts to address the failure(s) associated with each mode of regulation have, with time, led to tighter and more centralised forms of control, and an encroachment on clinical autonomy and professional discretion. The existing limitations, illustrated by the state's historical (and ongoing) approach to regulation, reinforce the wider problem of controlling the profession in the first place. On the one hand, the state failed to regulate doctors once and for all at both the turn of the twentieth century and midway through at the inception of the NHS. This has continued to haunt successive governments' attempts to modify the delivery of Britain's health care provision. On the other hand, the medical profession's historical modes of regulation through self-governance, professional autonomy and minimal state intervention have helped to foster opposition to the current EC law among sectors within the health occupations. Ideologically, the Directive represents a centrally imposed legal control negotiated by politico-legal bargaining which is beyond the bargaining jurisdiction of UK doctors. Accompanying these trends are the cultural forces which buttress the medical profession's power. But, here is the puzzle: while the European Directive represents a mode of external regulation like none of the kind hitherto faced by the profession, it is intended to benefit doctors by way of improving their personal health and safety through imposing maximum hours at work. Will the profession adjust to the strictures of this new supranational legislation in the same way as it did vis-à-vis the modes of regulation implemented by the Conservative and New Labour governments? The Directive is not a domestic measure nor is it the outcome of sector-specific negotiations by the profession. Will this make a difference as to how doctors will respond to the legislation?

This chapter sets the scene as part of the study's attempt to explore this apparent tension between a conventional ideological standpoint on the issue of regulation, and the application of a beneficial, welfarist law to the work of a professional culture whose membership (and possibly ideas) is quickly evolving. It provides a background to the informants' responses to the EWTD in the latter chapters of the thesis.

Chapter 5

Regulating working time in the medical profession

Introduction

Drawing upon the analysis above of the attempts at regulating both the labour market and the medical profession, the discussions in this chapter address the sector-specific debates on the regulation of working time in the UK junior medical profession. The first part provides a detailed overview of the two co-existing forms of control which currently govern doctors' working hours, namely the New Deal and the EWTD. The intervention of the ECJ is assessed in some detail, which sets the scene for the second part of the chapter that reviews research on the impact of the legislation. The regulatory effects include doctors' health, work-life balance and salary, medical training, and medical staffing and services. The profession's responses, particularly if supported by the study's findings reported in the next three chapters, may help to explain the levels of EWTD compliance among junior doctors in the NHS.

By exploring such themes, the study attempts to provide a context within which it is possible to assess the impact of regulating working time on the work and lives of junior doctors. The debates covered by this chapter thus correspond to the third research objective and provide an important context for exploring the viewpoints of the study's informants reported in the next chapters.

The New Deal and EWTD

Agreed in 1991 between representatives of the medical profession, NHS Management and the government, the New Deal is a package of measures designed to improve the conditions under which junior doctors work (NHS Management Executive 1991). One of its key features is the limit it imposes on the working hours of junior doctors, and the working arrangements introduced to facilitate this. By 31 December 1996, junior doctor were not permitted to work beyond 72 hours per week for on-call rotas, 64 hours a week for partial shifts and 56 hours a week for full shifts. Under a partial shift system, a doctor would work a 'normal' day on most weekdays but, at intervals (depending on the number of doctors in the rota), would work a different pattern, such as evening or night shifts for a fixed period of time. At times, they could be expected to work substantial periods out of hours. A full shift pattern, on the other

hand, divides the working week into definitive time blocks, with doctors rotating through the shift pattern. These different working arrangements, including full and partial shifts to accompany the previous on-call rota system, were implemented in light of the New Deal package, with work patterns and workload intensity being critical determinants of whether alternative flexible working arrangements were appropriate. Limits were also set on maximum continuous duty hours, minimum periods off duty and between duty periods.

The New Deal was re-addressed in 1999 under the New Labour government which addressed shift patterns and rest requirements, together with a new pay structure in December 2000 aimed at restoring the impetus to achieve regulatory compliance. The latter was agreed in a context within which junior doctors had voted to strike if the issue was not adequately addressed. The final agreement between the Department of Health and the BMA replaced the system of additional duty hours (overtime for which most junior doctors received 50% of the standard hourly rate of pay) with a pay-banding system for different posts, reflecting such criteria as the amount of working hours, work intensity and the extent of anti-social hours. Under the new scheme, junior doctors are entitled to a basic salary and an additional supplement from their employers if they work longer than the amount stipulated in their pay band. Failure to maintain working hours within the limits permitted by the New Deal therefore allows juniors to be re-banded, leaving trusts with a heavier bill, and juniors a substantial pay supplement worth between 20 and 100 per cent of basic pay, depending on the amount and intensity of the out-of-hours work they do. In total, these features became a contractual requirement for each hospital trust to fulfil. From 1 August 2001, it became unlawful for PRHOs to be working more than 56 actual hours a week, or without sufficient rest. The same limit has applied for all other doctors since August 2003.

Financial penalties can be imposed if NHS trusts do not comply with these requirements and if they fail to monitor junior doctors' working hours. Progress, however, has been slow and many NHS trusts have been reluctant to face their obligations to introduce the necessary changes (Beecham 1999). A reciprocal duty is placed on the doctors to comply with the monitoring procedures. However, research carried out by the BMA (2003a) has identified resistance among junior doctors towards their obligations to comply with Trusts' monitoring exercises. The reasons underlying their actions varied, with some arguing that the obligation was not contained in their contract. Others were concerned about the managers' uses and aims of monitoring. Moreover, both junior doctors and Trust staff felt that monitoring was

not an accurate reflection of their working hours. It did not, for example, account for the circumstances in the different specialities, nor did it consider work intensity and the quality of working life. In separate instances, the BMA (2003d) has also found that many doctors do not believe that their hours are being monitored accurately, with some being pressurised to under-report their working time in order to portray the impression that their work patterns are compliant with the Regulations. The situation has led Northop and Hearn (1998) to argue that monitoring time will be a particular problem in the NHS, not least because of the complicated shift and working arrangements that characterise the working lives of doctors.

The available research therefore suggests that both Trusts and individual junior doctors are not fully participating in the UK regulatory process. This has been confirmed by a series of surveys. In 2002, only 2% of trusts in England and Wales reported that all training posts were New Deal compliant, with statistical variations among different parts of the country and medical specialties. Wales had the poorest rates of compliance, with only 20% of junior doctors' work arrangements conforming to the New Deal limits (BMA 2002). Recent statistical information from the Department of Health shows little improvement. Depending on which part of the UK, in May 2006 between 14 and 40 percent of all junior doctors were working more than 56 hours a week, or without adequate rest (BMA 2006a). Some of these figures are broken down below:

Table 1
New Deal Compliance

	England (Sept 03)	***Wales (Nov 03)***	***Northern Ireland (Nov 03)***	***Scotland (Aug 02)****
PRHO	*92%*	*100%*	*94%*	*81%*
SHO	*85%*	*61%*	*68%*	*41%*
SpR	*80%*	*40%*	*50%*	*41%*
Total	***84%***	***60%***	***72%***	***50%***

**Total New Deal compliance in Scotland for August 2003 was 73%; figures by grade were not available.*

(Source: BMA 2006a)

These statistics show a corresponding analogy between New Deal compliance and the junior doctors' level of seniority. It reports the PRHO group of this specific sector of the medical profession as the most compliant with the Regulations' provisions, particularly in Wales. For

all four countries, specialist registrars (SpRs) were found to be the least compliant. Wales was again highlighted, but this time for reporting the poorest compliance rates, which reduced its overall New Deal compliance below the reported levels of Scotland (its general compliance totalled 73% in August 2003, but figures by grade were not available), Northern Ireland and England. These figures suggest that while attempts to bring the work of the most junior members of the profession in line with the New Deal limits are generally successful, the conditions under which senior house officers (SHOs) and SpRs raise questions as to why these more senior ranks of junior doctors are unable to meet the regulatory requirements. The report does not allude to any reasons underpinning these trends and this study focuses on PRHOs, nonetheless the report is important insofar as it shows that compliance with the EWTD among junior doctors may be significant, given that the New Deal work-time requirements were stricter than the provisions contained in the Directive's initial implementation phase (discussed below).

PRHOs are employees of the NHS and have historically been a mainstay of service provision particularly at night and weekends. These have usually been manifested through long hours at work (Evans *et al.* 2004). An EC-wide survey (COM 2003) found that doctors in training exceed 55 hours per week on average in the majority of Member States, although recent studies show that these hours are gradually falling (Scallan 2003).

Junior doctors are also subject to the working-time limits imposed by the EWTD, following the implementation of the Horizontal Amending Directive 2003 (HAD). The latter provides for an average 48-hour weekly limit for doctors in training which is to be phased in over a period ending on 31 July 2009. The interim periods impose a 58-hour week and a 56-hour week in the Augusts of 2004 and 2007, respectively. They are limited to a shift of no more than 13 hours, followed by a break of at least 11 hours. In comparison with the EWTD, the terms contained in the New Deal were stricter initially. Both stipulate a maximum of 56 hours per week by August 2007, and after which point the Directive's 48-hour week will supersede the limits imposed by the New Deal.

Like that envisaged by the New Deal, the original intention of the European Commission was that working time, for the purposes of the Directive, would not include time spent resting or sleeping at the hospital. As the Commission noted in its implementation report, inactive time on-call or on standby was usually designated by Member States as falling into an

intermediate category where the employee is not carrying out work, but has to be ready to work if necessary (COM 2000). On this basis, such periods would not be included in the calculation of the maximum weekly working time and could be designated as a rest period of a rest break. Medical professionals believed that, as late as 1998, working time encompassed only activities actually carried out and excluded time spent on-call (Northrop and Hearn 1998).

The European Court of Justice has subsequently interpreted the concept differently in the 2002 case of SIMAP[4], classifying *all* time spent at the health centre as constituting working time. Thus whenever doctors are obliged to be present and available at the workplace with a view to providing their professional services, they are, for the purposes of the Directive, carrying out their duties and in fact working. The ECJ felt that any other interpretation would be inconsistent with the legislative requirements and the overriding health and safety objective of the EWTD (Para. 49):

> a doctor who is required to keep himself available to his employer at the place determined by him for the whole duration for periods of on-call duty is subject to appreciably greater constraints since he has to remain apart from his family and social environment and has less freedom to manage the time during which his professional services are not required.
>
> SIMAP, Para 65.

The decision was subsequently confirmed in the Jaegar case.[5] Giving his opinion in the latter case, the then ECJ Advocate General, Ruiz-Jarabo stated that on-call working should be considered in its entirety to be working time, even where the doctor in question is permitted to rest and sleep during periods of inactivity. The ECJ is not bound to follow the Advocate General's opinion, but it often does and did so in this case. The BMA (2004b) has welcomed the Court's approach that takes account of the perspective of the individual doctor who, according to the Advocate General, "is separated from his family, and cannot pursue his own interests since he has to remain in the health centre" (Opinion, para. 37).

---

[4] SIMAP v Conselleria de Sanidad v Consumo de La Generalidad Valenciana C-303/98.
[5] Landeshaup Kiel v Jaegar C-151/02 [2003] ECR

These ECJ rulings therefore extend beyond the New Deal requirements in addition to what was anticipated from the EWTD. As a result, the BMA calculated that from August 2004, there would be a loss of 213, 000 working hours a week, which would be the equivalent of 3,700 junior doctors (EIRO 2004b). In 2009, when the 48-hour week comes into force, it estimates that the total loss could be as high as 476, 638 hours a week or the equivalent to 9, 900 junior doctors. The rulings had a direct effect on other countries such as France, Austria, Poland, Slovenia and Hungary, which traditionally did not calculate all periods of on-call towards the working week (Watson 2007).

The Directive's interpretation therefore imposes a mammoth task on Member States to address the time spent by doctors undertaking resident on-call duties. Counter-arguments relating to the cost and extra difficulties of training and recruiting large numbers of doctors to guarantee the same level of care in order to comply with the EWTD were dismissed by the Court. It held that the Directive cannot be called into question by objections based on economic and organisational consequences because, referring to the preamble, the objective of improving workers' safety and health at work is one "which should not be subordinated to purely economic considerations" (Para 66-67).

The Welsh Assembly government produced a report, *Designed to Comply* (2005b) which evaluated the current position in Wales with regard to its levels of compliance with the EWTD, following the ECJ rulings. As of September 2005, 95.5% of NHS Trusts in Wales had achieved compliance with the 58-hour limit imposed by the EWTD, and approximately 29% compliance with the maximum 48-hour week to be implemented by 2009. Among its recommendations for improvement were the better structuring of rotas and out-of-hours care provision by a multi-disciplinary team, through such initiatives as the Hospital at Night; remodelling the medical workforce; and reconfiguring both local and national services. These are discussed between other proposals in the next section, which explores the perceived impact of the EWTD on the medical profession.

Impact of the European Working Time Directive

The EWTD has been embraced as a package of measures which extends beyond the health and safety objective upon which the EWTD was passed, and is aimed at introducing broader changes and modernisation to the National Health Service:

> The EWTD has provided an impetus for change and gives rise to the opportunity to redesign service delivery and improve the work/life balance for NHS staff.
>
> North West Wales NHS Trust 2002: 22.

These themes, together with other perceived regulatory impacts, form the second part of this chapter. Of particular concern to the medical profession has been the primary strategy adopted to implement and comply with the Directive's provisions, namely the systematic use of shift systems among juniors. This strategy has reduced doctors' working hours (Scallan 2003; Kapur and House 1998) but their discontent with these arrangements is common within what they claim are the knock-on effects of the legislation.

The remainder of this chapter discusses the themes most frequently voiced in the literature concerning the perceived impact of the EWTD. They include doctors' health as the legislative basis upon which the Directive rests; the effect of working-time regulation on medical training; and the broader changes to medical staffing and services. These debates address the study's objective to analyse the impact of regulating working time on the work and lives of junior doctors.

Doctors' health

Chapter 3 discussed the health and safety rationale underpinning the EWTD, in addition to research that both supported and questioned the health/hours relationship. On both humanitarian and patient-safety grounds, the regulation of working time is arguably long overdue (Davies 2003; Delamonte 1990; Spurgeon and Harrington 1989). The long working hours associated with the medical profession often portrays the vocation as "constituting a lifestyle rather than an occupation" (Bates 1982: 30). Findings have shown that the majority of staff working in the NHS (CHI 2004), and PRHOs in particular (Evans *et al.* 2004) enjoy their jobs, and their satisfaction derives from the perception that their work is important insofar as it involves caring for people (Bates 1992). This is arguably one factor explaining

the reasons why 75% of all healthcare staff work beyond their contracted working time (CHI 2004).

Various studies on the health of the medical profession (Evans *et al.* 2004; Hardy *et al.* 1997; Caplan 1994; and, for other NHS staff, see CHI 2004) have illustrated the damaging effects of working long hours. They have found higher levels of fatigue and stress among doctors in comparison with the general population. Furthermore, doctors have been recorded as having experienced more instances of psychiatric care, depression, drug dependency and alcoholism than members of the same socio-economic group (Cartwright *et al.* 2002; Moss *et al.* 1996; Firth-Cozens 1987; Firth 1986). Among these doctors, numerous studies have shown that it is PRHOs who, as the most junior members of the profession, report the highest levels of mental and physical ill health (Kapur *et al.* 1999; Grainger and Harries 1995; Dillner 1993; Reuben 1992; Hale and Hudson 1992; Morrice 1984; Valko and Clayton 1975). These findings accord with studies on doctors which argue that job-related pressures decrease with age (Kirkaldy *et al.* 2002; Burke and Richardsen 1990; Linn *et al.* 1985); however Ahmed-Little (2007) points to the detrimental impact of shift work on senior doctors. Firth-Cozens (1987), for example, argues that the negative impacts of medical work diminish with age, seniority and experience, and the first postgraduate year remains the riskiest one of all.

Similar to those general studies reported in chapter 3, the working environment also has moderating effects in the complex working hours and health relationship. The type of work undertaken by doctors is of a challenging nature, often requiring social, physical and highly cognitive skills. Junior doctors are on a very demanding learning curve, are required to establish effective working relationships with both patients and colleagues, and must deal with the complexity of the modern hospital administration from an early vocational stage (Kirkaldy *et al.* 2002; McKee and Black 1992; Bates 1982). Burke and Richardsen (1990) correlated high workload, economic problems and family concerns with poor health among young doctors. Such factors fall outside the European Directive's ambit, and give rise to the argument that its impact will be, to a certain extent, diluted until the extra work conditions are addressed. The responsibility for addressing this environment falls with the Member State, the profession and hospital managers rather than with the EC.

Despite the high reporting of adverse health conditions among doctors, evidence points to their reluctance to consult an occupational health service or a similar independent medical

practitioner (Forsythe *et al.* 1999; Baldwin *et al.* 1997*b*; McKee and Black 1992). This phenomenon is arguably a result of the traditional 'culture' within which doctors work, that assumes they are 'immune' to poor health (Cassidy and Griffiths 2004). By virtue of the Article under which it was passed, the EWTD explicitly attempts to address such poor health within the EC labour market by reducing working hours. However, doctors' continued long hours, illustrated by their non-compliance with the New Deal, gives rise to three paradoxical situations. The first relates to the way in which professionals dispensing with medical services are themselves experiencing poor health (Firth-Cozens 1987). Secondly, while shift work has reduced the working time of many doctors in line with the EWTD's requirement, it has, for some, intensified the existing workload by insisting that the same amount of work must still be completed within a shorter period (Ahmed-Little 2007). The implementation of shift systems in light of a health and safety directive has therefore led to increased stress (Barton and Folkard 1995; Cole *et al.* 1990), fatigue and poor performance (Ahmed-Little 2007), and psychological morbidity among house officers (Kapur and House 1997). The third paradox relates to the health and safety of the patients treated by these doctors. Some findings have strongly correlated intense shift patterns with medical errors (Shabbir *et al.* 2005; Mather and Pounder 2004; Paice and Reid 2004; Dula *et al.* 2001; Petersen *et al.* 1994), particularly among house officers (Houston and Allt 1997).

As a result, we are faced with a European Directive that attempts to address the health and safety of both doctors and their patients on the one hand, and the widespread implementation of shift systems to achieve regulatory compliance which is posing a health risk, on the other. Errors are not confined to doctors alone either. In one major recent survey, 47% of NHS staff reported having seen at least one error that could have hurt either staff or patients in the previous month (CHI 2004). Caution should be taken in interpreting these findings as the relationship between shifts and errors is not conclusive (Harrington 1994; Rosa *et al.* 1989; Butterfield 1988; Poulton *et al.* 1978; Wilkinson *et al.* 1975). Other factors also play a role, such as fewer doctors being on duty at any given time and the potential problems of accessing specialist expertise in the event of an unanticipated emergency. Discussions surrounding medical staffing are discussed below.

Doctors' work-life balance and salary

The wide implementation of shift work among junior doctors has afforded more doctors with a greater opportunity to apply for flexible, part-time and family-friendly working arrangements (Scallan 2003; Vassallo *et al.* 1992; Nasmyth *et al.* 1991; Wilkinson *et al.* 1975). Other studies, however, have found that shift work has not necessarily improved doctors' quality of life (Allen 2005). For example, night work has been seen as particularly disruptive on home and social life (Sim *et al.* 2004; Paice and Reid 2004; Mather 2002a; Baldwin *et al.* 1997*c*). The effects are being realised now with research identifying low job satisfaction and high staff turnover at a time critical to achieve EWTD compliance (CHI 2004). From a sample of 1, 326 of junior doctors, 48% said they would either leave the UK or medicine altogether (Moss *et al.* 2004). The BMA has also been promoting a 'retainer and returner' scheme that assists those doctors who might otherwise leave medicine altogether because of family or other commitments. One such policy is the assistance provided to NHS students who must bear childcare costs during their studies (TUC 2004b). In a bid to recruit and retain professionals who have extra commitments, mature students, single parents and those with partners on a low wage, the £17 million fund is anticipated to benefit approximately 6,000 students a year which will cover up to 85% of their childcare costs.

Resistance to the Directive may have been fuelled by some doctors' concerns over the effect of shorter working hours under the shift system on their salaries. The prospect of flexible training and obtaining a better work-life balance is not conceived as a priority for all (Allen 1994). Reasonable reductions in pay are generally lawful to take account of the diminution in working hours (DTI 1996). As discussed above, junior doctors' out-of-hours work was conventionally remunerated according to a banding scheme based on the expected intensity of their workload during 'additional duty hours' (ADHs). The busiest posts (allocated to class one) were remunerated at the normal hourly rate of pay, while the majority of PRHO posts were categorised as class three and paid at 50% of the basic rate (BMA 1999).

The revised pay structure was agreed in a context within which junior doctors had voted to strike if the issue was not adequately addressed. The final agreement between the Department of Health and the BMA replaced the system of additional duty hours (overtime for which most junior doctors received 50% of the standard hourly rate of pay) with a pay-banding system for different posts reflecting such criteria as the amount of working hours, work

intensity and the extent of anti-social hours (BMA 2002). Under the scheme, junior doctors are entitled to a basic salary and an additional supplement of up to twice the basic rate from their employers if they work longer than the amount stipulated in their pay band. Failure to maintain working hours within the limits permitted by the New Deal therefore allows juniors to be re-banded, and penalising Trusts with a heavier financial burden, and juniors obtaining a substantial pay supplement worth between 20 and 100 per cent of basic pay, depending on the amount and intensity of the out-of-hours work they do.

A monitoring exercise in 2003 indicated that up to 30% of junior doctors contracts in the surgery speciality attracted the full pay supplement because they were working above the 56-hour weekly limit (EIRO 2004b). Moreover, this limit did not include the estimated 32 hours of time that junior doctors were resident at hospitals while on-call, which is now calculated as part of the working week under the EWTD's interpretation. Professional opposition to the regulation may therefore be shaped by a degree of self-interest in the form of a reduced salary in line with fewer working hours.

Medical training

The career progression from medical school to consultant grade currently takes between 12½ and 18 years. At the time of writing, the table below shows the typical structure in hospital-based medical careers:

Table 2
Medical training programme

Steps	Time period	Options	Requirements
Medical school entrant			A Levels and places
Medical school graduate	5-6 years	School drop out, or exam failure, or choose another career, or progress to PRHO	Formal education, practical work and adequate degree
PRHO Post	1 year		A degree and a 'College' acceptance
SHO	2-5 years	Non-medical work or progress to SpR	Approval by a 'College Dean', mentoring, direction, training, clinical experience

			and research
Specialist Registrar (SpR)		Staff doctor, other medical work or progress	An appropriate CV
Obtain qualification (Certificate of Completion of Specialist Training, CCST)	4.5 – 6 years		
Consultant	Total 12.5-18 years	Non-consultant career grade or GP	A CCST and a post

(Source: Compiled by author, 2007)

The PRHO programme, which is a local application process, mostly paper-based, with regional variations, has now been replaced by the first year of the Foundation Programme. This is a national application process, mostly electronic, with all foundation schools and deaneries adhering to a set timeline, common scoring guidelines, and national personal specification. Upon successful completion of Foundation Year 1, doctors will then generally progress into Foundation Year 2 (or the equivalent SHO year under the older process).

The 1950 Medical Act introduced a system whereby every qualified doctor must spend a period known as the pre-registration year as a resident house officer in an approved hospital before being fully registered with the General Medical Council. The year aims to enable them to apply the key skills and knowledge gained during their undergraduate training and, on completing the necessary clinical training, to demonstrate their readiness to accept responsibilities of a fully registered doctor and to begin specialist training (GMC 1997). It is spent gaining basic experience in hospital specialties and, since 1998, time in general practice (GMC 1998). The PRHO year therefore encompasses a mix of both service and training, though in reality the two are inextricably linked.

The EWTD's reduction in working time means that the existing system of medical training must be addressed. For many, as a result of the apprenticeship-like method of medical training, less time spent at hospital translates into reduced clinical exposure and fewer opportunities to experience procedures (Williams and Cantillon 2000; Sim *et al.* 2004). The Directive is therefore perceived by some as a measure depriving medical graduates of their opportunity to spend more time at the hospital (Alkhulaifi *et al.* 1995). Some doctors consequently claim that regulation is lengthening their period of training (Gillard *et al.* 1993)

while others express concern as to the EWTD's long-term impact, in terms of reduced clinical exposure on their confidence to practice (Devey 2005) and subsequent career progression (Kapur and House 1998), giving rise to the claim that trainee doctors will need to gain relevant experience more efficiently or spend a longer period training (Marron *et al.* 2005). Such arguments are supported by the Royal College of Surgeons (RCS), which has calculated that, by convention, junior doctors require some 30,000 hours' exposure at work before achieving consultant grade (Phillip *et al.* 2003). With the new changes to the system this figure is set to fall to between 6000 and 8000 (Godlee *et al.* 2005). It is from this point of view that some of the literature predicts greater clinical inexperience among those at consultant grade in the future:

> Nothing will account for the experience gained from high exposure to a wide variety of different conditions. In medicine, not all cases are straightforward, and the ability to deal with unusual and often unpredictable situations are best enhanced with time.
>
> Shabbir *et al.* 2005: 728.

The substitution of monolithic shift patterns for the previous on-call arrangements has therefore been perceived as damaging junior doctors' experience and clinical exposure, by rigidly confining their working time to prescribed periods of the day. This has been viewed as negatively affecting their training (Baldwin *et al.* 1997; McKee and Black 1992). Estimates of the decrease in training hours are as high as 79% in the case of trainee surgeons (Chesser *et al.* 2002). Even preceding the Directive, the surgical trainee struggled to obtain adequate operative experience (Williams and Cantillon 2000). The reduction in hours is therefore viewed by some as exacerbating an already unsatisfactory situation:

> The reduction in junior doctors' hours does not satisfy trainee surgeons' need for operative experience and abolishes the continuity of care many other professionals work long hours. It is time that the senate of the Royal Colleges of Surgeons said no to Europe's directives.
>
> Scott-Coombes 2002: 736.

The commentary therefore suggests that the issue is better dealt with at a sector-specific level. Resistance towards the EC regulation echoes the profession's recent discontent with the increased managerial and statutory regulation discussed in chapter 4. Self-regulation

therefore continues to be voiced as the most appropriate medium for addressing such fundamental employment terms as working time, despite evidence of non-compliance with the New Deal as negotiated by doctors' representatives.

The literature extensively documents concerns by both junior and senior doctors vis-à-vis the reduced training time under the EWTD regime, but their claims have been fuelled by the assumption that the amount of exposure equates to the quantity and quality of medical training (Scallan 2003). Lending credence to such anxieties is the expectation among some medical specialities, such as surgery, that juniors must carry out a minimum caseload. Aspects of their medical competence are therefore judged by a quantitative caseload. Some research has found that trainees are, for the first time, failing to achieve the currently recommended case numbers, and this pattern has been attributable to the implementation of the EWTD (White *et al.* 2005).

The longstanding tension between junior doctors' training and service (that is, the work for which they are employed by the Trusts to do) is exacerbating the situation. The literature acknowledges the conflict between the two aspects of the juniors' work, and largely concurs with the view that more often than not the former takes priority over the latter (Scallan 2003; North West Wales NHS Trust 2002; Paice 1998; Panayiotou and Fotherby 1996; Gillard *et al.* 1993; Leslie *et al.* 1990; Dally *et al.* 1984). Furthermore, evidence shows that the time spent actually undertaking 'service' is not effectively utilised. Many of the tasks assigned to junior doctors are still perceived as having very little or no educational value. These would include significant amounts of time (as much as one-fifth of PRHO time according to Bogg *et al.* 2001) engaged in inappropriate clerical activities such as filing, dealing with forms and finding beds (Lambert *et al.* 2000; Wilton 1995; McKee and Black 1992; Leslie *et al.* 1990). Of the junior doctors in their study, Lambert *et al.* (2000) found that 80% felt they were performing routine work that did not require a medical qualification. In 1995, the Audit Commission reported that while routine tasks were a necessary part of the job, it was inappropriate for trainees to spend a considerable proportion of time undertaking them (Audit Commission 1995). Evidence suggests that this impinges on juniors' health and job satisfaction (Scallan 2003; Gillard *et al.* 1993; Spurgeon and Harrington 1989), and Goldacre *et al.* (1999) found that 9% (out of 2,926 respondents) were considering leaving medicine as a result of these trends.

Concerns over medical training and service have therefore prompted calls for a better structured working environment within which junior doctors work (Schuwirth and van der Vleuten 2006). These approaches may, in turn, offset the impact of their reduced hours (Marron *et al.* 2005; White *et al.* 2005). While there is a shift away from a quantifiable assessment criterion towards a competence-based model, some specialities, and surgery in particular, continue to demand an element of case numbers (Sim *et al.* 2004). Teaching methods should be adapted to include the use of simulators (for example, latex models of organs), anaesthetised animals (for laparoscopic and endovascular procures), or computer generated virtual reality (for example, laparoscopy, endoscopy). Undertaking more work outside the typical working day, obtaining supervision and detailed feedback, and carrying out tasks which are clinically suitable for their service/training are ways of elevating both training opportunities and quality. Suggestions like these, however, can only be accompanied by changes in cultural attitudes:

> A move to shift working without a change in the culture of training and the instigation of innovative working patterns is likely to have a negative impact on training.
>
> Paice and Reid 2004: 336.

The medical profession must therefore adapt in line with the environment created by the regulatory requirements. This will extend beyond a mere change in their teaching methods and assessment criteria to a broader outlook on how training should be delivered and the role of service played under the new regime.

Another challenge to the longstanding rigidity of full-time medical training is being brought about by the increasing number of junior doctors choosing to train on a less than full-time basis, under which they are required to work a minimum 50% of the equivalent full-time training programme over a two-year period (Williams and Cantillon 2000; Goldacre *et al.* 1999). The literature commonly refers to this programme as flexible training (BMA 2004e). Its demand has increased in line with the number of female medical graduates (Schofield 2005) and female doctors who now account for 35% of the medical workforce (Department of Health 2004). Given the broader trends in the UK labour market (Millard and Machin 2007; and see chapter 3), it is likely that many women will want to both work and train part-time (Fox 2007). In the UK, however, only some doctors are considered eligible for flexible or part-time training. They include those with a disability, those with childcare

responsibilities, and responsibilities for a disabled relative (Goldberg and Maingay 1997). However, there are very few opportunities to train part-time, and findings show that junior doctors are consequently abandoning the profession as a result of this inflexibility (BMA 2004c). The CHI (2004) similarly found that 34% of all health-care workers often thought about leaving the NHS as a result of the way in which working time was organised.

However, research shows that flexible training is negatively perceived by many within the profession (Allen 2005; Allen 1994). Many of the juniors claim that the two-year period is too lengthy, less interesting and detrimental to the quality of training and career progression. It is also thought that certain specialities are unsuitable for part-time training. In spite of these findings, half the UK's 39,000 junior doctors would like to work part-time, many of whom are men (Schofield and Schofield 2005; TUC 2003b; Grant *et al.* 1990), although a number of NHS trusts are reluctant to fund them (EOR 2003; BMA 2001). This phenomenon is fuelling a concern particularly as the number of female medical undergraduates and doctors is rising (Goldberg and Buckley 2000). Given their family aspirations, together with an increased demand among men for flexible working (Goldberg and Buckley 1998), the organisation of working time in medicine is likely to be addressed sooner rather than later (Allen 2005). For example, research shows that the speciality of surgery does not appeal to many women given its tradition of long working hours and consequent incompatibility with family life (William and Cantillon 2000).

Medical staffing and services

Discussions surrounding the impact of the EWTD have highlighted the additional pressure it will exert on a national health system that already faces existing difficult questions on medical staffing and services. The issue of staffing numbers is considered first, with a second section later focusing on reallocating of both clinical and non-clinical work.

Staff numbers

The number of all doctors employed by the NHS has steadily risen from 80, 064 in 1995, to 114, 470 in 2005 (NHS Workforce Statistics 2006b). Of these, the number of doctors in training has increased from 16, 523 to 25, 981 in the same period. The challenge posed by the EWTD's maximum working-time provisions, as of August 2004, is that there will be a loss of some 123,000 working hours in the medial profession, which equates to 3,700 junior doctors

(BMA 2004d). Progression towards the stricter 48-hour limit is estimated to cause a further loss in junior doctor cover of between 208,296 and 476,638 hours, which is the equivalent to between 4,300 and 9,900 junior doctors. The permanent working group has calculated that an extra 6727 doctors are required – an increase of 21% - if compliance with the Directive's maximum weekly hours is a realistic prospect (CPC 2003; Hellawell *et al.* 2005; Molloy 2003; Hunter 1991).

The reduction in hours therefore dramatically reduces the availability of doctors, and has sparked debates about staff recruitment and retention (Pickersgill 2001). In the long term, an expansion in the number of medical students, an increase in training of these numbers, and the recruitment of more consultants would facilitate the implementation of the EWTD, while maintaining care at the appropriate standard. The short-term strategies have been to identify how the work carried out by junior doctors can be properly redistributed among other healthcare staff in tandem with the universal introduction of shift patterns (Morran *et al.* 2005).

The allocation of extra places at medical schools across the UK provided an additional 500 doctors in training in 2005 and this number is set to increase to between a further 500 and 1000 per annum up to 2009 (Guardian, 18/03/2004). Although this strategy was to initially increase the number of doctors working in the NHS, its effect will be largely absorbed by the EWTD requirements (CPC 2003). Despite the ongoing recruitment, the NHS faces other difficulties owing to its structure of healthcare and medical provision. As a consultant-led service, 50% of all clinical services are provided by consultants and the remaining 50% by doctors in training. In addition to their clinical services, consultants are required to supervise junior doctors, and many also undertake teaching responsibilities at medical school. Current trends show that the proportion of time that they allocate to providing clinical services has declined, and this is scheduled to continue with the recruitment of more junior doctors who themselves demand the time of their seniors (Pickersgill 2001; Baldwin 1997*a*).

Over the past decade, the number of consultants per junior doctor has risen from 0.65 to 0.7 (CPC 2003). It is uncertain what impact the EWTD will have on this ratio but it is clear that the recruitment of junior doctors alone is inadequate. New Labour has sought to expand the number of consultants currently working in the NHS (Department of Health 2003a), but the system continues to be under pressure (Frauenfelder 2006; DDRB 2006). Alongside the issue

of medical recruitment, one should not lose sight of the importance regarding the recruitment and retention of existing healthcare staff who support doctors. This is a matter discussed below.

Among other difficulties facing the regulation of NHS doctors is the funding of this service. It is effectively 100 per cent public sector, and providing substantial alternative private care is not easily achievable. Medical schools also currently operate at full capacity so that throughput of graduates cannot be increased without expansion. Overall, the 'home' recruitment of more doctors may not therefore be the best solution (MacDonald 2003; Thorpe 2002). This has fuelled the debate on employing European and overseas doctors to alleviate some of the more immediate staffing problems in the NHS resulting from the juniors' reduced hours (Fox 2007). For policymakers, the use of the overseas doctors also has the key advantage of avoiding the perverse incentive of 'rewarding' consultants for undertaking private sector 'initiative lists' on NHS patients with long waiting times (Rosen 2002). Recruiting foreign doctors also offers a quick solution to increasing the number of senior clinicians while addressing patient waiting times.

Implementation, however, is slow, and this is partly attributable to professional opposition among doctors in the UK. Some of these concerns stem from the consultants' desires to protect private practice (Rogers and Carr-Brown 2002). Fox (2007) argues that the GMC and the Royal Colleges try to insulate the UK labour market from the external market, and immigration law is used to control entry from overseas (that is, non-European), thereby controlling the supply of medical providers. The state plays a similar role by funding only a certain number of university medical places. He argues for the need to recruit them to address the short- and medium-term demand but acknowledges the ethical dilemma in draining poor countries in Africa of their trained staff. There is some trepidation over the training standards of migrant doctors who have failed to be employed elsewhere, and who may have gained their only experience through free practice (Bearley 1991). Some overseas medical graduates have consequently failed to gain access to some aspects of hospital medicine (Hale and Hudson 1992). There is also evidence to suggest that foreign doctors are themselves reluctant to practice in the UK owing to their comparatively poorer pay and conditions in the NHS (Miles *et al.* 2002).

In response to the staffing issues, proposals have encompassed the combination of split sites with the consequential closure of smaller units to provide a centralised cover for out-of-hours services (Hellawell *et al.* 2005; North West Wales NHS Trust 2002). This prospect is particularly the case for smaller and rural Trusts where the EWTD requirements require that staff are spread thinly, sometimes across larger geographical areas. The strains posed by regulation on such areas are reflected in the compliance statistics. In 2002, one study reported that UK compliance with the New Deal was at its lowest in rural Wales with only 20% meeting the Regulation's demands (Gould 2002). As a result, investment has gone into more innovative ways of providing care from 'centralised hospital points'. These methods include the use of IT and technology, such as telemedicine, which reduces the need for doctors to be physically available at peripheral sites or smaller units. Video conferencing for some meetings and even training sessions are equally being utilised to reduce doctors' travelling time across long distances in the more rural trusts (North West Wales Trust 2002). These developments, however, do not accord with the New Labour's commitment to the local provision of NHS Services (Sim *et al.* 2004).

The reduction in doctors' hours and consequent services has, according to the Royal College of Physicians, meant that one in five hospitals will be hard-pressed to provide adequate emergency services (Edwards 2003; Economist 2003*b*). A 22% decrease in the number of patient cases and a 14% decrease in the number of weekly operating lists were found among senior house officers in anaesthetics (Sim *et al.* 2004). Since the implementation of the EWTD, the mean number of operating lists has decreased for certain specialities by as much as 13% (White *et al.* 2005). Sim *et al.* (2004) and Tomlinson (2005) similarly found a 17% and 20% decrease, respectively. The impacts are greater in hospitals with fewer trainees who work a more frequent rota. There is considerable variation, too, among specialities. Figures for operating experience among surgical trainees, for example, show a 20%-70% decrease after the introduction of new working patterns (Chikwe *et al.* 2004; Newman 2005).

Reallocation of tasks

Other approaches towards performing the work junior doctors are unable to do during their time at the hospital have looked towards the re-assignment and delegation of tasks to the existing health workforce. In addition to the variable views among juniors regarding their service requirements (Scallan 2003), the BMA has recommended in the light of both the EWTD weekly working hours and current medical staffing levels the better use of

experienced nurse to perform those tasks hitherto confined to the medical profession (BMA 2003).

The provision of care by non-medical professionals has been the subject of much research in light of the EWTD's maximum working week for junior doctors. In August 2005 the NHS National Workforce Projects (NWP) was awarded the contract to support the NHS in developing and implementing practical solutions to achieve compliance with the Directive's requirements. It aims to support NHS organisations achieve their workforce objectives and focus on particular needs and challenges that the NHS has identified to ensure practical implementation of the Regulations. Working alongside a range of organisations including the Department of Health and NHS representatives, the Medical and Nursing Royal Colleges, Junior Doctors, unions, National Patient Safety Agency, Modernizing Medical Careers, NHS Trusts, the GMC and NHS Employers, the NWP among other strategies explores ways in which current roles can be adapted through various projects (NWP 2005). It follows the work of the government's Modernisation Agency. Established in 2001, the Agency has conducted various pilots across a spread of NHS Trusts and medical specialities to seek the most feasible and appropriate means of implementing the EWTD. The pilots focused on a variety of work arrangements, including the use of existing and new non-medical staff (such as pharmacy technicians and physicians' assistants) and the extension of healthcare roles to conduct responsibilities hitherto confined to medical doctors. The government provided £46m to assist Trusts to implement the EWTD, and more than £5m was allocated to the 19 pilot sites (Department of Health 2003b).

Recent case studies carried out by NWP include looking at ways to reduce the need for junior doctors' presence. They have explored the role of IT to improve handover procedures between medical teams, the introduction of new roles, such as Health Care Professionals, and the reduction in the number of overnight rotas during which junior doctors are expected to reside at the hospital. As such time spent resting and sleeping falls within the ambit of what constitutes working time according to the ECJ rulings, this is an attempt to moderate the number of doctors present at the hospital at the quieter times of the day. Time has been spent looking at the possibility of merging different tiers of doctors to determine whether using more than one grade of doctor on a rota is enough to provide the necessary levels of care (Academy of Medical Royal Colleges 2004; Department of Health 2003d). Cross-cover arrangements have been developed, integrating several rotas, so that doctors may cover one

specialty in the day, one or two in the evenings and weekends, and several at night. Doctors will therefore become generic medical staff at night practicing general skills, but will carry out work specific to their specialty in the daytime (Department of Health 2004). This is designed to give non-medical practitioners responsibilities hitherto confined to doctors in training. Doctors in training may still need to provide out-of-hours cover to meet their training needs, but could do so alongside other practitioners.

One significant concept is the Hospital at Night initiative (HAN). It was not designed to deal with the EWTD, but is clearly relevant to the current discussions. It aims to redefine how medical cover is provided in hospitals during the out-of-hours period. The programme entails a move from cover requirements defined by professional demarcation and grade, to that defined by both competency and which is most appropriate to the service demands. Tasks could therefore be done by more suitable staff as part of a multi-disciplinary team, thus fully utilising junior doctors in what is claimed is an appropriate manner (Department of Health 2004). The initiative will change work practices insofar as it will release significant amounts of medical staff time. Doctors will also work as part of a multidisciplinary team comprising other professionals in healthcare during the night periods. Some specialities, notably anaesthetics, obstetrics and paediatrics, require medical skills which can not readily be provided by other staff, and for them other arrangements have to be made. In many of NWP's cases, this involved dispensing with the services of relatively unskilled PRHOs at night, thus ensuring compatibility with the EWTD, while increasing the number of experienced junior doctors. The BMA has confirmed the effectiveness of the HAN model in reducing the need for such employing high numbers of doctors during these periods (NWP 2005).

The HAN is similar to the concept of the Out-of-Hours Medical Team (OoHMT) (Academy of Medical Royal Colleges 2004). Like HAN, the OoHMT aims to provide the necessary quality of care while optimising the efficient use of medical staff. The multidisciplinary team would attend and assess patients with acute deterioration of health at night. This represents a further move to team-working and flexibility across various specialities, utilising sufficiently competent staff. The development of multi-professionalism, building on the gradual expansion of senior medical and allied health professional numbers, has commenced alongside a vision to modernise working practices in line with the EWTD (Department of Health 2003c). Consideration has also been given to the configuration and rationalisation of health services in light of the EWTD's implementation (Academy of Royal Medical Colleges

2004). Practical solutions involve hospitals within a locality effectively collaborating to provide suitable out-of-hours medical cover between different sites. In secondary care, for example, nurses have already taken on the responsibility for coordinating a range of services that include outpatients' clinics, minor injury services, and cardiology day care (Lissauer 2002).

Such an integrated approach towards providing medical and healthcare has therefore seen the gradual disintegration of the conventional consultants' medical team or 'firm' (which comprised a consultant, middle grade support, one or more SHOs and a PRHO). Pre-Registration House officers arguably no longer feel part of a team because they can work at times for up to ten consultants (Vassallo *et al.* 1992):

> Junior doctors now operate a shift system, and leave hospital as promptly as any bureaucrat leaves his office, in mid-crisis if the clock so dictates. The aim of each shift is now to keep the patient alive until the next shift takes over, when he ceases to be the departing doctor's responsibility.
>
> Dalrymple 2003: 15.

Representing the profession's concerns, Mather (2002b) argues that shift systems have infused a 'clock-watching mentality, lack of ownership and responsibility and a short-term attitude to patient care, coupled with a lack of team spirit, which is affecting doctors' overall morale and job satisfaction. As a consequence of this perception, the recruitment of junior doctors in certain specialities has been adversely affected (Hellawell *et al.* 2005) and some hospitals have received fewer applications for training posts after their implementation of shift systems (Kapur and House 1998). It seems, however, that evidence of widespread resistance to shift patterns depends on the training grade and medical speciality (Aitken and Paice 2003).

Compliance with the EWTD will necessitate the need to move further away from the 'firm' as it is no longer feasible to depend on the prolonged presence of junior doctors at the hospital. A shift towards multi-professional teams nevertheless goes some way in addressing this. It also promotes inclusive working practices which utilise the skills of all staff (North West Wales NHS Trust 2002), while ensuring reduced hours for junior doctors (Dash and Jones 1995). The 'healthcare team' arguably turns previous "confrontation between doctors

and nurses into a more fruitful dialogue about shared care" (Devadas 2001: 939). Some members of the medical profession, however, have voiced their anxieties about adopting this strategy (Doyal and Cameron 2000). Implementing it will require careful planning:

> Doctors and nurses have separate roles in a team, and for very good reasons. Nurses and doctors are not synonymous, and increasing skill mix does not mean that we can just appoint 'consultant nurses' and the European Working Time Directive will magically work. Skill mix means finding the best way to use your team resources in delivering care – not just giving tasks currently done by junior doctors to nurses.
>
> Thorpe 2002: 67.

Delegating and redistributing tasks is a sensitive issue, and one that can provoke tensions between the different professionals in the NHS. Kneebone and Darzi (2005) found that some junior doctors feared a diminution in training opportunities as a result, and perceived the changes as a threat to established lines of clinical responsibility. The University of London's report (1991), for example, identified some offence caused towards nurses who were requested to assume the menial tasks that doctors perceived as being a waste of their valuable time. Shabbir *et al.* (2005) also found instances of professional opposition to the extension of roles hitherto confined to medically-qualified personnel:

> The problem is the middle of the night you have to have someone to make the decisions, and that is what you've trained doctors for. You need people with the skills to take in a lot of complex information and make diagnoses.
>
> Edwards 2003: 24.

Implementing such a strategy will require the collaboration of all professions to ensure that staff competency and training is readily available. It should not, however, be discarded merely based on the idea that because it is by convention a 'medical' task, then it should not be re-distributed to another worker. While there is a perceived need to accelerate the skill mix of staff, it is nevertheless important to define what is both appropriate and adequate according to each individual role (Davies 2003). In particular, tasks should only be undertaken by individuals competent and trained to perform them with clear protocols and guidelines in place for how and when decisions are to be made within the scope of defined professional practice (North West Wales NHS Trust 2002). Extended roles therefore require significant

investment, but this approach is hoped to improve patient care in the long term (Shabbir *et al.* 2005) through an integrated approach to the delivery of care (Devadas 2001).

In addition to the development of existing staff roles, the NHS has created new roles to ease the pressures on the current medical and healthcare professions. The use of non-medical anaesthetists (Sim *et al.* 2004) together with advanced nurse practitioners (Hellawell *et al.* 2005) and physician assistants have helped to achieve a reduction of junior doctors' time and work intensity. This policy has by and large helped to secure New Deal compliance (North West Wales NHS Trust 2002). Phlebotomists have been introduced into the NHS to take patient blood samples while radiographers have undertaken extended roles in X-Ray, such as ultrasound, appendicular trauma reporting and IV injections for specific procedures in scanning. These are again tasks hitherto restricted to medical doctors. Trusts are seeing the benefit of adopting a broader view in assessing whether tasks and roles such as these can be done by someone else other than junior doctors (North West Wales NHS Trust 2002). The emphasis is placed on maximising clinical time corresponding with the removal of administrative tasks from both nursing *and* junior medical staff. Non-clinical and administrative duties should be dealt with by other personnel more appropriately suited to those responsibilities particularly as such tasks do not contribute to the junior doctor's training (University of London 1991; Leslie *et al.* 1990).

Conclusion

Given the nature of their professional roles, the long hours associated with their work, and the underlying rationale of the Directive, one would assume that doctors would welcome regulation on working hours. After all, the maximum working week is intended for their benefit by way of promoting better health and quality of life. The importance it attaches to the protection of NHS users by ensuring that they are not treated by exhausted doctors also conforms to the professional ethos of serving the patients' best interests. Why, then, is the regulation so controversial? The chapter has attempted to set out this puzzle by looking at its different facets to acquire an understanding of the outlook from which doctors argue for and against the legislation's form and content. Debates in the previous chapter surrounding the profession's ideological opposition to the EC legislation – on the basis that the Directive represents a highly centralised mode of regulation which is beyond the conventionally confined bargaining jurisdiction of doctors – is matched in these discussions with an equal

resistance to the application of the EWTD, for its perceived failure to take account of the unique working demands of medical practice, such as training, staffing and service provision.

The questions which remain to be answered are whether such views are supported by this study's findings. How are the political and legal debates surrounding the regulation of working time explored this far manifested in the medical, political and judicial spheres? How has the EWTD been implemented and enforced in practice, and has this shaped resistance or support for the regulation? And, are the issued raised in this chapter about the Directive's impact echoed among junior doctors currently undertaking their training?

In line with the broad aim to analyse the process and impact of legal regulation on working conditions in UK labour markets, with specific reference to the EWTD and its impact on the junior medical profession, the next three chapters report the study's findings. In turn, they analyse the views of elite stakeholders about the political and legal debates surrounding the regulation of working time. They then examine critically the ways in which the EWTD has been implemented and enforced in practice. These themes, once further developed, will explore the sources of support and resistance to such processes. Finally, I analyse the apparent impact of regulating working time on the work and lives of junior doctors.

Chapter 6
The Debate about Regulation

Introduction

This chapter is the first of three which present the research findings. It explores the perceptions of elite groups on the issue of working-time regulation, with specific reference to the EWTD, drawing upon qualitative data gathered from interviews with policymakers, medical service providers, and the judiciary. It draws upon the literature in chapter 4 by highlighting the problem of regulating doctors in light of their historical modes of regulation. In particular, this chapter addresses the tensions associated with state intervention and the medical profession's longstanding mode of self-regulation (Freidson 1970a), within which the work of doctors has been characterised by clinical autonomy (Harrison 1990a). These traditions have subsequently fostered opposition to the legislation among elite members of the medical profession. This ideology was applied in chapter 5 by referring to the perceived impact of the legislation on individual facets of junior doctors' work and personal experience, such as their health and work-life, medical training, and medical services.

However, these earlier chapters also showed how all three of these modes of regulation – self-regulation, new public management and statutory control – are, to varying extents, now simultaneously visible in the way that junior doctors' hours are being organised. The position is therefore far from clear cut, and the distinctions between self-regulation and external regulation are blurred. The state's deliberate 'fudging' of the regulation and the ECJ's intervention has broadened the demarcation between those elite informants who welcome the legislation and argue for its continuance, and those who resist it in preference for other modes of regulation that resemble self-governance models. The majority of senior doctors interviewed made it clear that they fall within the latter category and, whilst supporting the broad principles of the EC legislation, they reject the reality of its operation. The fundamental paradox in the views of elite stakeholders lays a foundation upon which the EWTD's implementation and compliance can be assessed in chapter 7 and its perceived impact in chapter 8.

This chapter builds upon the earlier reviews documented in the literature in an attempt to understand the claims made by elite informants in this study which both embrace and oppose

the regulation of PRHOs' working time. It addresses the study's objective to analyse the views of elite stakeholders about the political and legal debates surrounding the regulation of working time. The first section explores informants' views about the various modes of regulation and the strengths and limitations of each model. It explains why many informants initially embraced a Directive that represents a form of centralised control, and which contrasts significantly with their historical forms of self-governance. The second section explores the intervention of the ECJ which has subsequently led to elite figures being critical of the legislation. This has given rise to the paradoxical situation in which doctors, as participants in a health-based profession, vehemently criticise a measure interpreted by the judiciary in such a way that explicitly prioritises their health. The discussions conclude with an overall assessment of the findings reported in this chapter.

The principle of EC regulation

In light of doctors' tradition of working long hours, the principle of enacting EC regulation to set a maximum working week attracted general support among the elite informants. It was suggested that establishing supranational legislation to regulate these work conditions would be a preferable alternative to a domestic measure for two principal reasons. First, the conditions under which the medical profession's working time was previously governed had neither reduced doctors' long hours nor had they improved their personal health. Secondly, the EWTD was designed with both these concerns in mind by stipulating a maximum working week underlined explicitly by health and safety objectives. This section maps out the respondents' views about the various modes of doctors' regulation in an attempt to understand the context and reasoning relating to the elite informants' *prima facie* support of EC regulation in principle.

Clinical autonomy, a fundamental characteristic associated with self-regulatory arrangements in the medical profession, has historically meant that doctors have not been subject to the same degree of state intervention in the 'industrial' sense as other workers in the UK labour market (Freidson 1970a). The literature reviews in Chapter 4 have already highlighted the links between clinical autonomy and self-regulation. Doctors were permitted to arrange their work to suit their own clinical and intellectual preferences, and the autonomy allowed them to diagnose and treat patients free of prescribed clinical guidelines, audits and 'performance indicators' (Harrison 1990a). Fuelling the medical profession's self-regulation and its general

dominance over health administration and policymaking was an exclusive knowledge to which only doctors could gain access (Stacey 1992). This has been complemented by the historical minimalist approach to work regulation by the state (Salter 2002) and the voluntarist nature of employment relations operating in the wider labour market (chapter 3). A small number of informants in this study continued to celebrate the values of voluntarism, and therefore opposed supranational legislation on this basis. For one MEP, domestic self-regulation using doctors' specialist knowledge and experience to arrange their own work conditions was preferable than more intrusive forms of governance represented by the EC:

> It should be regulated and negotiated between the UK Parliament and the BMA. Each country has a different culture and different work practices, and the BMA are the specialist body who can do this for Britain.
>
> MEP, Conservative.

These principles generally accord with the way in which the medical profession and employment relations have been conventionally organised. However, in line with his Conservative beliefs, this informant's approach to regulating the labour market was predictable given the wide deregulation policies initiated by his party during the 1980s. His views were even more unsurprising when considering the response by the Thatcher and Major governments to the process of European social regulation and the EWTD in particular (see chapter 3). A senior EC Commissioner in Brussels responsible for producing and enforcing EC legislation represented the opposite view and, having regard to the UK's historical voluntarist arrangements, explained the significance of the Directive in Britain:

> We have to distinguish two different situations: in much of Europe there were already laws on working time with limits lower than the Directive...in the UK there was no such statutory limit, and there the Directive could have much more impact.
>
> EC Commissioner.

The differences between the regulation of European and UK labour markets therefore underscored the value of the EWTD for workers in Britain whose employment conditions and general long working hours had hitherto been determined by collective bargaining and minimum state intervention. Like the Conservative MEP, the EC Commissioner's response was not surprising given his position within the EC's central legislative body. The other

policymakers and medical service-providers (the medical profession and their representatives) tended to share this perspective rather than that proposed by the MEP, but for reasons other than political beliefs. They approached the issue in a more pragmatic way by reference to the failed attempts to tackle doctors' long working hours by previous professional/domestic modes of regulation. Both the Paediatrics consultant and the Deputy Chair of the BMA's Junior Doctor Committee (JDC) concurred that that the most appropriate way to address these working conditions was to use centralised and statutory forms of control:

> There have been plenty of opportunities through gentleman's agreements in the past unless you legislate things won't change. Our Health Department and trusts were reluctant to change until they were forced to.
>
> Deputy Chair JDC, BMA.

Self-regulation and clinical autonomy within the broader voluntarist context seemingly came at too high a price, and penalised junior doctors in the form of long working hours, which consequently risked their health and safety. These concerns laid a platform upon which calls for a degree of regulation were voiced. The perceived limitations of self-regulation ultimately meant that an alternative mode of regulation was put forward by the state. This intervention came in the form of the New Deal (NHS Management Executive 1991).

The New Deal represented an arrangement between the state and the medical profession to address a set of concerns, each relating to the working time of junior doctors (chapter 5). For the profession, the long hours' culture was an occupational feature that was adversely affecting doctors' welfare, and the implications of a sick workforce was an anxiety the government wished to address. The agreement heralded a move towards a 'hybrid' regulation confined to the profession alone, in line with Britain's patchwork history of sector-specific measures (McIvor 1987). The New Deal attempts to regulate junior doctors' working time, among other conditions, in such a way that complements their medical training and service requirements. It is a mode of regulation by the profession which seeks to protect its members from the long hours of work associated with self-regulation while also keeping state intervention at a minimal level. However, the Agreement's non-statutory basis and civil sanctions have diluted its impact. Non-compliance had, according to the senior policy advisor

at the Royal College of Surgeons and a Medical Director, come about as a result of the Regulation's lack of statutory rigour:

> The New Deal was not adequate. That's why the legislation was brought in. If a decision has to be made to reduce hours of work, consensus doesn't seem to have produced that [then EC legislation] is fine.
>
> Medical Director.

Having both practised medicine in the past, these two clinicians believed that the civil sanctions for non-compliance, underscored by the poor rates of regulatory compliance (BMA 2006a), were seen as fundamental weaknesses in the existing system. The perceived failure to regulate working hours in the medical profession through the New Deal was therefore a sufficiently compelling reason for the elite stakeholders to support alternative European modes of regulation which would provide the necessary form of sanctions if the provisions were not observed. This was explicitly outlined by both policymakers and medical service providers alike, including the Deputy Chair of the BMA's JDC, the Assistant Junior Doctor Coordinator at the Welsh Assembly Government (WAG), and a Dean and Director for Postgraduate and Medical Education whose responsibilities included the welfare and training of junior doctors practising throughout Wales:

> I don't think that without the move towards the EWTD and the change in European law, [the employers] wouldn't have taken much action...
>
> Dean and Director for Postgraduate and Medical Education, Wales.

The School of Postgraduate Medical and Dental Education manages the delivery of training programmes delivered by fourteen NHS Trusts and dental and general practices across Wales. Its Director believed that the new pay structure concluded in 2000 (chapter 5) had exerted more pressure on NHS trusts to reduce juniors' time spent at hospital, but the absence of criminal sanctions followed-up by external enforcement agencies had resulted in the continuation of long working hours and instances of poor health among the doctors training under his deanery.

A significant proportion of the elite informants therefore expressed support not only for a statutory base to progress the juniors' labour conditions, but also a highly centralised measure external to both the UK and professional jurisdictions. This view highlights a significant departure from the longstanding modes of regulation which have hitherto governed the UK medical profession's labour conditions. The concept of a European regulation also reflects doctors' discontent with their profession's previous attempts at dealing with the working environment effectively. Unsatisfactory commitment to New Deal compliance has underscored the paradoxical failure of a health-based profession to protect the welfare of its own members. Furthermore, the inadequacy characterising attempts by both the state and the profession to address doctors' work hours has contravened their broader interests of ensuring patient welfare, by potentially subjecting their treatment to fatigued and ill doctors.

The EWTD incorporated two features, the lack of which, according to the elite stakeholders, rendered ineffective the previous modes of regulation. They included the statutory nature of the Directive accompanied by both criminal and civil sanctions, and the explicit promotion of doctors' health and safety. The EWTD prescribes a phased approach between 2004 and 2009 to reduce the time spent by all medical professionals, both senior and junior, to 48 hours per week (chapter 3). Its legal status and sanctions were perceived as predominantly distinguishing this form of regulation from the New Deal. The legislation therefore carries a far heavier weight than a contractual agreement; in addition to its civil penalties, like those contained in the New Deal, its potential to imprison hospital chief executives gave the measure, in the view of the study's elites, considerably more impact. As pointed out by the Director of NHS Employers and the Assistant Junior Doctor Coordinator at WAG, the EWTD's ability to both fine and imprison employers for non-compliance with the European regulation had sparked anxieties among hospital managers. It had been a factor driving them to implement measures which reduced junior doctors' long working hours (these measures are discussed in chapter 7):

> Factors that have contributed to the decline in PRHO working hours have largely been associated with the trusts' awareness of the need to comply with the Directive – the obligations imposed on them and the anxieties resulting from the potential criminal sanctions for non-compliance.
>
> Assistant Junior Doctor Coordinator, Welsh Assembly Government.

The work of the Junior Doctor Coordinator at WAG meant that she was well placed to provide detailed insights about the political policies and compliance issues vis-à-vis the EWTD and junior doctors. Her position routinely brought her into contact with NHS Trusts in Wales which in turn provided her with a familiarity with concerns and feedback voiced by medical staffing managers in relation to the Directive's obligations. Among others, a Plaid Cymru Assembly member concurred with her views. His experience as both a GP and a politician permitted him to present matters from a politico-clinical viewpoint. He concluded that statutory measures supported by enforceable criminal sanctions afforded his profession with the best opportunity to change the ways in which the working time of doctors was regulated. The perceived differences in how Trusts had treated the issue of junior doctors' working hours before and after the EWTD reinforced and legitimised the informants' dissatisfaction with the working environment under the self-regulatory arrangements and the New Deal.

The principle of European regulation was also embraced positively by reference towards its aim for improving the health of doctors and patients. The long working hours associated with the self-regulatory regime meant that little priority was afforded to the welfare of doctors. By contrast, the EWTD is a measure introduced under Article 118a of the EC Treaty, and thus legally serves as a health and safety legislation. In addition to limiting working hours, the New Deal did stipulate some measures to improve the working environment for junior doctors, namely their provision of accommodation and catering facilities, but there was no explicit link to the effect of working time on health and safety. It was for these reasons that the Dean and Director for Postgraduate and Medical Education promoted the EWTD:

> I am completely behind the health and safety issues that have driven the legislation. The [work] intensity has increased so much that one has to be careful about these things, the way the job works, the work-life balance, and so on.
>
> Dean and Director for Postgraduate and Medical Education, Wales.

Drawing from her personal experiences, a Consultant in Palliative Care (who was also an elected member of the BMA ethics committee and a member of the House of Lords) also supported the emphasis on the importance of doctors' health and safety. She also welcomed its concern for patient welfare, having almost performed what she saw was a serious medical error years ago as a result of working excessive hours. The informants were divided,

however, in relation to the Directive's potential impact on the health of doctors. Given that the Commission was responsible for passing the legislation under the relevant Article, a European spokesperson predictably supported an "evident link" between long working hours and poor health. Nevertheless, he acknowledged that "there are not many studies focusing specifically on 48 hours", and that previous research had been concentrated on individual countries and labour market sectors. This lack of conclusive evidence, as pointed out by a senior policy advisor at the Health and Safety Executive, was sufficient for many informants to question the straightforwardness of the hours/health link. The literature similarly provides an unconvincing answer to the relationship (Trimpop *et al.* 2000; Spurgeon *et al.* 1997; Baldwin *et al.* 1997*a*; 1997*b*; Cooper 1996; Harrington 1994). An industrial officer at the Royal College of Nursing and a Dean of Medicine, among others argued, that the stressful nature of the work inherent in the NHS compounded by staff shortages impinged more directly on occupational health and safety as opposed to the quantity of working hours per se:

> I'm not sure whether you can directly correlate [ill health] to working hours. I think a lot of it is due to the fact that being a junior doctor is a stressful job. At the end of the day, you have peoples' lives in your hands. When you're young and inexperienced, that 'is' stressful.
>
> Dean of Medicine.

In spite of the informants' inconclusive view on the Directive's health and safety impact, the principle of EC regulation and the EWTD specifically was supported for its potential influence on challenging the long hours' culture which had traditionally permeated medicine. Previous attempts to regulate the environment within which this culture worked had not been perceived as effective instruments in limiting the working week. A Consultant Anaesthetist partially agreed with the principle of regulation as its absence may, in turn, lead to people being "abused". Some groups, according to him, would "stand up for themselves, others won't". Of particular concern was the symbolic safety net provided by EC regulation, which was seen as protecting junior doctors from being encouraged to work the long hours experienced by their senior counterparts. Making the illustration was a Consultant Surgeon whose teaching responsibilities included both undergraduate and postgraduate medical students:

> They are far more protected and far more supported than what they used to be.

Consultant Surgeon.

The difference between what used to be the norm (that is, the situation determined by self-regulation and the New Deal) and what is now the standard to which doctors and their employers must comply under the EWTD, illustrates the transition between the medical profession's various modes of regulation. In return for a reduced clinical autonomy, which was a primary facet of self-regulation, the junior doctors and their seniors expressed a desire for more protection and support. This reinforces the argument developed above which ironically shows how a profession charged with medical responsibilities was unable to protect the health of its own members under previous modes of regulation. As a result, doctors have sought support from a continental legislature which is completely external to the profession. The safety of patients has similarly been elevated by their protection from being treated by doctors who are more susceptible to poor health and fatigue as a result of working long hours. The degree to which these broader principles translate into practice is assessed in Chapter 8.

Looking at professional self-regulation and the New Deal has highlighted a series of criticisms which have cumulatively allowed a certain approach to work to materialise. This approach has entailed long working hours and poor health as a result, though the correlation between the two is debatable owing to their complex interaction including social, environmental, occupational and personal factors. In the views of this study's respondents, this materialised because neither previous mode of regulation had been supported by criminal sanctions; this deficiency ultimately meant that trusts were not sufficiently motivated to strictly observe the relevant requirements. The European Directive – at least in general terms – had been embraced by the elite informants on the basis of these principles, despite it representing a form of regulation far from which doctors have traditionally been accustomed. However, both medical service providers and policymakers were disappointed with the shape that the EWTD had taken in practice following judicial intervention in Europe. This forms the discussion of the next section.

Interpreting working time

Anticipation among the elite informants for a supranational regulation which addressed the shortcomings of the New Deal and the self-regulatory arrangements in the medical profession was illustrated by their initial support for EC regulation of working hours. Poor rates of

compliance with the domestic regulations concurrently matched by long hours of work and poor health underpinned the perceived need for the EWTD. This enthusiasm, however, appeared to have dissipated quickly following the European judiciary's interpretation of the law, thereby reinforcing the paradoxical situation in which doctors, as participants in a health-based profession, vehemently criticised a measure interpreted by a Court in such a way that explicitly prioritised their health. This section spells out these contradictions, and explains why EC law disappointed the senior stakeholders, particularly in the medical profession, to the extent that a European measure was now resisted implicitly in favour of deregulation or a pre-EWTD arrangement resembling the New Deal. Thus certain informants ironically reverted to supporting forms of regulation whose failures led to calls for the Directive in the first place. These complex and contradictory arguments raised a collage of different forms of working- time regulation none of which individually satisfied doctors and other senior stakeholders owing to the perceived inadequacies inherent in them all.

Until the ECJ rulings on the EWTD, elite groups were content with an EC regulation in principle which, on health and safety grounds, prescribed a statutory maximum of working hours. Tensions had subsequently arisen as a result of the definition of working time applied by the Court. The SIMAP ruling in October 2002 interpreted working time as including any physical time spent by the doctors at the health centre or hospital for the purpose of providing his or her professional services (Chapters 4 and 5 analyse the judgments and their practical ramifications in further depth). The subsequent case of Jaegar confirmed the definition, explicitly stating that on-call working should be considered in its entirety to be working time, even where the doctor was permitted to rest and sleep during periods of inactivity. Representing the welfare and work-life balance of junior doctors, the Deputy Chairman of the BMA's Junior Doctor Committee welcomed the rulings insofar as they "recognised that being on-call at the hospital is not the same as being [on-call] at home". Officials at the Welsh Assembly Government (WAG) supported this argument, as did a New Labour MEP whose party oversaw the implementation of the Directive:

> To not constitute this as working time may only be a short-sighted solution to long working hours and may defeat what has progressed over the years, under the New Deal agreement and the EWTD.
>
> Assistant Junior Doctor Coordinator, WAG.

For these informants, ensuring higher standards of health and safety necessitated less time at the workplace. Their responses, however, were also shaped by their party's political policy. By covering complete time spent at work within the definition of working time, the ECJ had interpreted the EWTD in such a way that explicitly dealt with the perceived inadequacies of the medical profession's previous regulatory attempts to regulate its members' excessive working hours and consequential poor health. The UK judge who presided at the ECJ in the case of SIMAP argued that he, along with his colleagues, merely gave effect to the legal philosophies of the legislation:

> The ECJ was not asked to say whether the policy of the Directive was sound or what would be its practical impact on the health services of the Member States the Court can only go by what is found in the preamble.
>
> Ex-ECJ UK Judge.

The preamble of the EWTD unequivocally sets out the basis of health and safety upon which the legislation rests, and the need to restrict time spent at the workplace for that reason. Including 'all' time spent at the workplace, irrespective of whether the doctor was 'resting' or 'working' was an attempt by the ECJ to restrain employers from insisting that doctors spend long amounts of time at the hospital by justification of applying a narrow definition of working time. While such an approach directly benefits doctors, the majority of informants in the senior medical profession paradoxically preferred the far narrower definition of working time they had assumed the Court would adopt, which would consequently expose them to the possibility of longer working hours and poorer health. For them, working time was anticipated as excluding time spent resting or sleeping at the hospital while on-call. This assumption derived from the stated intention of the European Commission as legislature not to include periods of rest, standby or inactive time on-call within the definition of working time (COM 2007). Coincidentally, this was also the basis upon which the New Deal had defined its working time (NHS Management Executive 1991). The EWTD therefore represented a conflict of intentions between the ECJ's actual interpretation of the law on the one hand, and what the profession and legislature had anticipated on the other:

> I am going to be frank and say it was a surprise. The Commission has always assumed that the definition of working time has been straightforward this was not the intention of the legislature.

EC Commissioner.

The confusion between the different stakeholders' intentions had resulted in an outcome which policymakers and professionals alike deemed unsatisfactory. From an operational viewpoint, the Director of NHS Employers argued that "the Court rulings had caused problems" to the general operation of the Health Service by restricting the hours and consequent presence of doctors at the hospital at any given time, thereby exerting demands on the existing staff shortages (Fox 2007; Hellawell *et al.* 2005; Edwards 2003). From a clinical perspective, the Senior Policy Advisor at the Royal College of Surgeons argued that the rulings adversely affected medical training by reducing junior doctors' presence and subsequent exposure to medical procedures (Williams and Cantillon 2000; Sim *et al.* 2004). Overall discontentment with the ECJ's unanticipated intervention therefore related to the judiciary's failure to consider the demands on national health systems and the specificity of medical training. A substantial cohort of elite informants argued that the European regulation was insensitive to these specific occupational concerns of the profession.

The SIMAP and Jaegar rulings were perceived as imposing a common standard that did not account for professional autonomy; the effect, discussed by a number of informants, was summarised by a Professor and Head of Anaesthetics and Intensive Care Medicine, who also held the positions of Non-Executive Director in a NHS Trust and the President Elect of the Association of Anaesthetists of Great Britain and Ireland:

> The problem with any regulation or rule is that they are written in such a way as to absorb everybody. There is a world of difference, for example, between being on-call in anaesthesia and being on-call for dermatology. You cannot put them in the same basket and say that on-call for one equals on-call to another.
>
> Consultant Anaesthetist.

The Consultant Anaesthetist, among others, was particularly critical of the monolithic nature of the Directive's interpretation and its attempt to enforce a one-size-fits-all regulation. This line of reasoning stemmed beyond debates confined to the individual application of the EWTD to a broader critique of EC law. A number of elite informants who initially agreed with the principle of European regulation therefore expressed different views at a later stage of the interview when asked about their views on the Court's interpretation of the law. On

discussing their opposition to the judicial interpretation of the EWTD, it became apparent that some informants were basing their views on what they saw as the Directive's effect of standardising workers' conditions across the European labour market, irrespective of their professional status and perceived work demands:

> Doctors [are being turned] from professionals into people that come in to do their job; they clock-in, they clock-out
>
> Consultant Anaesthetist.

By nature, medicine was differentiated from other occupations on the basis of its continual need for training and exposure to the clinical environment. This in itself inevitably involved longer working hours:

> Surgery is not something where at eight o' clock you can drop your tools and walk out. If something is going pear shaped on the ward, and they are my patients, then I stay until things are sorted
>
> BMA Junior Doctors Representative for Wales.

Many senior members of the medical profession agreed with this view, which derived from their conventional approach to external intervention. A significant proportion of them criticised the application of a monolithic form of regulation for its perceived failure to take account of the unique concerns voiced by profession, including medical training as noted by the RCS above; patient services, according to the BMA representative; and medical and health staffing which was highlighted by the Director of NHS Employers. These views corresponded to a broader ideological critique of the Directive as a centrally imposed legal control negotiated by politico-legal bargaining which was beyond the bargaining jurisdiction of UK doctors. Its failure to conform to an arrangement which was the product of internal and sector-specific discussions had led to an occupational resistance within the higher ranks of the medical profession. The historical modes of regulation through self-governance, professional autonomy and minimal state intervention had helped to foster opposition to the current EC law among many senior doctors. This outlook can also be understood by considering the state-medico relationship in the UK, and the longstanding influence of the profession over successive governments' policymaking (Macdonald 1995). Within the European arena, doctors in Britain lack comparable historical ties with the Commission, as

legislature (Greenwood 2003). The profession's concerns are afforded no more priority than those voiced other lobbyists and interest groups.

The ECJ's intervention had given rise to a perceived crisis of legitimacy between the EC state legislature and judiciary. Its definition of working time had left health systems across Europe ironically facing a measure introduced under the rubric of health and safety which had made the operation of national health services inoperable:

> It is now clear that we are in a situation after the Court rulings that almost all Member States are now in breach of the Directive at least 22 of the 25.
>
> EC Commissioner.

These unanticipated judgments had led to a state of non-compliance across European health systems that echoed the UK's position under the New Deal, and which led to calls for the EWTD in the first place. It is from this perspective that one is able to understand the magnitude of the judiciary's intervention, and the anxieties surrounding the perceived need to preserve a narrower and more exclusive definition of working time. Officials of the European Court of Justice, both past and present, were afforded the opportunity to respond to such criticisms. Accepting the present state of uncertainty, dissatisfaction and widespread non-compliance were issues for which the judges were not prepared to accept responsibility. The current Advocate General of the European Court of Justice at Luxembourg argued that the Court *was* concerned to ensure that its judgements could be complied with. The UK Judge presiding at the ECJ in the cases of SIMAP and Jaegar maintained, however, that contentious judgments such as the EWTD rulings frequently generated blame aimed towards the Court. They maintained that unanticipated and sometimes unpopular decisions by the judiciary were rooted in the legislature's failure to write unambiguous legislation:

> I'm afraid it is common nowadays for governments and the Commission to write unclear texts and then complain when they are interpreted in a way they did not expect. Even worse is the tendency to produce legislation that amounts, in practice, to little more than a politically correct wish-list, the effect of which, if taken literally, is to make as is alleged in the present context, to make the hospitals unworkable because there aren't enough junior doctors on-call. The remedy is not to blame the courts but

> for the political institutions to decide what they want to achieve in practice, to write legislation that means what they want it to mean, and to exercise some self-restraint in proclaiming programmes they can't (or don't want to) live up to.
>
> Ex-ECJ UK Judge.

The ex-ECJ judge argued that the primary onus rested with the EC Commission and Member States to produce more explicit legislation in order to preclude the potential for subsequent judicial interpretations that may not accord with the intention of the legislature. He was aware that many of the Member States would have preferred a particular result that would have excluded time spent resting at the hospital from the definition of working time, but these views could "not be a determining factor for a court of law". The Court was simply asked to interpret the Directive in the context of fact situations specific to SIMAP and Jaegar. The practical implications of the judgments were not within the judiciary's remit of deliberation. This was a matter explicitly reserved for the legislature. The current Advocate General sitting at the European Court in Luxembourg concurred with his colleague arguing that much of the blame for differences between anticipated and unanticipated results was attributable to the Member States:

> You very often have a number of Member States agreeing on a form of words simply because it is ambiguous. They know it's going to be interpreted differently among Member States. They also know that if this caught the intention of the Court, then one interpretation would be held to be correct and the other would not.
>
> Advocate General, European Court of Justice, Luxembourg.

For these senior members of the British and European judiciary, the judgments gave effect to the health and safety objectives of the Directive as spelt out in its preamble, and in the absence of any other definition to the contrary. Their claims, however, were not shaped by a critique of the states' inability to write clearer legislation. Rather, both judges referred to the legislature's deliberate attempts to implement an ambiguously worded regulation. It is arguable that the fundamental terms – the definition of working time – of the EWTD were framed in such a vague manner in order to provide the space to limit its practical impact of the regulation, and to reduce the constraints and difficulties it might cause for particular sectors.

The informants in the present study chose not to follow this line of argument. If blame was to be allocated, then the Court and not the state/legislature was to constitute the primary target. Why was this so? Members of the medical profession and their representatives concurred with existing state policy that working time should not include inactive time while on-call. As discussed above, this intention was made explicit by both the Conservative Government and New Labour's continued approach to the matter under the New Deal provisions. Furthermore, the EC Commission had echoed its similar intentions in its legislative proposals. On this occasion, the state and the profession collectively agreed on the policy, but it was the Court which disrupted the status quo. Directing blame at the ECJ has therefore deflected from the state (and the profession to a lesser extent) of its responsibility for clarifying the matter within the legislation itself.

The prospect of altering the judicial rulings was unlikely, which exacerbated tensions between the judiciary and other stakeholders:

> The Court is very, very rarely willing to reverse its previous case law, especially if it's very recent case law. They are not formally regarded as precedents, but they are.
>
> Advocate General, European Court of Justice, Luxembourg.

Revising the definition of working time was therefore doubtful. A decline in support for the EWTD among key stakeholders had subsequently emerged from this realisation, together with poor compliance across Europe with the present definition of work time, and the legislation's failure to accommodate the specific concerns voiced by the medical profession. Using such bases for opposing the nature of the Directive represented a wider argument against the principle of EC legislation in general to regulate workplace issues. This line of argument leaves few alternative options available, among which include domestic arrangements such as self-regulation and/or the New Deal, both of which catered for the medical profession by endorsing a less inclusive definition of working time.

Assessment

It is inevitable that tensions will emerge from the implementation of external intervention on a professional sector of workers whose historical form of governance has been through self-regulation (Stacey 1992). The debates in chapter 4 show how the clinical autonomy of

doctors has been gradually restrained over time through the ascendancy of both managerialism and statutory control by the state (Harrison and Ahmad 2000). The medical profession's response in the past to the changes in their delivery of care under a national system and under new public management have illustrated the doctors' struggles to retain a degree of independence from external control which mirrors their historical form of self-regulation (Freidson 1994). In the present context, the study's findings show that that the profession departed from some of its longstanding outlooks on work regulation by calling for a degree of state intervention in the form of a centralised statutory base. Such calls were motivated by poor health of junior doctors in light of their long working hours which had developed in the general absence of regulation, even though the validity of the relationship between the two variables was the subject of contention (Beswick and White 2003). Furthermore, the sanctions for non-compliance with the New Deal provisions were perceived as being ineffective in limiting the juniors' work hours, which also failed to improve their health.

For a number of the study's elite informants, these factors laid a foundation upon which they could argue for a different albeit a narrow mode of regulation – the EWTD. The third party intervention of the ECJ and its redefinition of the Direction's ambit had, however, led the senior members of the medical profession to consider the previously criticised regulatory arrangements that were in place preceding the EC law. The implication arising from this approach suggests that the profession was satisfied with the regulation until the judicial intervention. As a result, the informants reverted to support the New Deal arrangements. This comes as no surprise given that the latter's principles and scope are far broader and more flexible in nature than the ECJ's narrow and specific definition of working time. Such principles correspond with their historical autonomy to work free from external restrictions. Two significant points emerge from these views. The first relates to the reversion among the study's elite informants to a form of regulation which jeopardises the individual interests of doctors. Secondly and partly related to the latter point, it highlights the policymakers' deliberate attempt to 'fudge' the regulation.

First, the rejection of the ECJ's intervention in favour of a more loosely defined form of working-time regulation associated with long working hours and poor health highlights a paradox in the elite informants' views. They criticised the interpretation of a measure which aimed to improve the health of a profession charged with providing medical care.

Furthermore, they reverted to a measure actually knowing from experience about its implications for poor health in practice. In doing so, the senior members of the medical profession were also blurring the modes of regulation, creating overlaps between self-regulation and intervention. This supports the claim made in chapter 4 which shows how different modes of regulation are all, to varying extents, simultaneously visible in the way that junior doctors' hours are being organised. This complexity was reflected in the general inconsistency of their views.

Secondly, the current situation has been exacerbated by the state's deliberate 'fudging' of the regulation. Two senior judges referred to policymakers' calculated attempts to draw up legislation of such an ambiguous nature, thus leaving room for judicial intervention. This is in line with the UK's historical minimalist approach to workplace regulation (Bishop and Mayer 1995; Dawson *et al.* 1988) and is stimulated by concerns voiced by both industry and governments which prioritise the benefits of market competition and flexibility within the economy (McIvor 1987; Hart 1987). By ambiguously framing the fundamental terms of the EWTD, the legislature shaped this particular law with reference to the state's longstanding concern to ensure that the UK labour market operated with as few restrictions as possible, and that the essence of competition was not constrained by regulation (Hutter 1997). The vague nature of the Directive provided the space to limit its practical impact and to reduce the constraints and difficulties it might cause for particular sectors in the labour market, such as the medical profession, who have been accustomed to a high degree of working autonomy (Edelman 1992).

Considering the broad nature of the legislation and the available room for interpretation, it comes as no surprise that compliance between Member States' national health systems, following the ECJ rulings, was inconsistent. Nor is it surprising that many of the medical elite oppose the Directive in its present form. In addition to its effect on their autonomy to interpret the regulation as they see fit, their criticisms of the ECJ's intervention for its insensitivity to the specificity of medical work and the particular concerns voiced by the profession support the claims contained in the medical literature reviewed in chapter 5 about the perceived impact of the EWTD. However, the findings in this chapter suggest that those concerns, internally held by the profession, are contradictory, which thus raises questions as to what criteria must be satisfied for the doctors to accept any particular form of regulation. Parts of the profession are obviously concerned over the health and welfare of their junior

members, hence the call for EC law. There is also another outlook which argues against the imposition of a rigid legislative standard for other reasons, such as medical training, staffing and services. However, the absence of such a standard jeopardises junior doctors' health. One of the few ways to accommodate these conflicting concerns is the implementation of an ambiguous standard which can be flexibly defined to meet the various priorities.

This may explain why many of the elite medical informants initially embraced the principle of EC regulation. Their support was a symbolic statement which approved of a measure protecting junior doctors' individual welfare. This contrasts with their rejection of the reality of the law in operation, which was seen as adversely impacting on other aspects of junior doctors' work. The law therefore has both an expressive function – sending out a strong message about what is acceptable and what is not acceptable – and an instrumental one – to actively impose controls on particular kinds of behaviour (Yaegar 1991; Kuhn 1961). Discussions discerning the potentially symbolic and realistic impact of the law are further developed in chapter 7 by focusing on the enforcement of the Directive. Its authority, resourcing and other sources of support are explored to assess whether the policing mechanisms put into place will be able to control one above any other of the profession's contrasting concerns. The present state of ambiguity also lays a foundation upon which the EWTD's implementation and compliance can be assessed in the next chapter.

The differences between the symbolical and operational aspects of the regulation also illustrated a paradox by the medical profession's reluctance to alleviate some of the more pronounced difficulties regarding the perceived impact of the regulation, by an absence of lobbying for further medical staffing and resourcing, and initiating internal changes. In spite of the conflicting concerns referenced in this chapter, which are reviewed in more detail in chapter 5, doctors have not argued to increase their numbers to accommodate the EWTD's implementation. They have not abandoned their profession's social closure or attempted to make its restricted entry more accessible (Fox 2007). This experience is arguably shaped by the profession's historical roots (Larson 1977) and longstanding mode of self-regulation, which have conventionally addressed work issues in a manner suited to the members of the particular sector, and particularly those that are in a position to define the organisation and operation of the sector.

The exclusive nature of the profession and its close socialisation processes facilitate the transmissions of ideas and a unified approach to issues such as workplace regulation (Stacey 1992). It is not therefore in the interests of the doctors to increase medical staffing as widening their vocational access would jeopardise their occupational unity and the unanimity in some of the longstanding ideologies permeating the profession. These views are the key reference points within which junior doctors operate. The next chapters explore this contextual paradigm to assess whether the strong views of the senior doctors identified in this chapter are supported by the juniors, in the discussions on EWTD implementation and impact.

Conclusion

These findings show that a significant proportion of elite informants who initially welcomed EC law in principle subsequently opposed the form it took in practice because of its perceived failure to accommodate the concerns surrounding medical training, patient services and staffing pressures. This has given rise to a puzzling situation in which leading voices in the profession are consequently arguing for the implementation of modes of regulation which resemble the arrangements that were in place before the EWTD. These criticisms that were levelled towards the individual models, however, led them to call for European regulation in the first place. The position therefore leaves the elite stakeholders facing a variety of policy options, none of which are satisfactory owing to the perceived inadequacies in them all.

Opposition to the EWTD after the ECJ's intervention has given rise to a paradoxical situation in which doctors, as participants in a health-based profession, strongly criticise a measure that explicitly prioritises their health. Discussions on this issue therefore show the profession's ongoing inadequate response to the concern and welfare of its members, in line with the general discontent voiced towards working time arrangements under the self-regulatory and New Deal regimes. Debates on the role of the Court also support a more general argument about the state's deliberate attempts to limit the impact of the regulation through ambiguously framing the terms of the legislation. This issue is discussed in further details in the study's conclusions.

The views of the elite stakeholders have been far from consistent. Initially accepting the principle of EC law only to subsequently oppose it underscores the ideological tensions

which are influenced by the medical profession's historical modes of regulation on the one hand, and the need to address junior doctors' health through controlling their working hours on the other. The state's failure to regulate the profession once and for all, as highlighted in the conclusions of chapter 4, thus continues to pose difficulties in the modern context. The findings raise certain questions on how these tensions and apparent contradictions are played out in practice when the regulations are implemented at the hospital trust level. These issues are explored in the next chapter.

Chapter 7

Attempts to Manage the Directive

Introduction

This chapter bridges the broader arguments about the regulation of the medical profession made in chapter 6, with the actual experiences of doctors and their managers at the hospital level. In line with the study's objectives, it aims to examine critically the ways in which the EWTD has been implemented and enforced in practice in relation to junior doctors, and the sources of support and resistance to such processes. The first section looks at the roles played by the state and managers in the implementation of the Directive, and explores how the process has shaped regulatory compliance with the current limits, and what implications this has for the stricter provisions in 2009. In so doing, it draws on the literature in chapter 3 which discusses the tensions between the Department of Health's ongoing commitment to the voluntarist tradition of managing employer-employee relations in the UK underscored by the previous Conservative governments, with the new legal commitment to statutory limits on working hours (Exworthy and Halford 1999; Dawson *et al.* 1988).

In light of the senior doctors' general opposition to statutory controls discussed in chapter 6, shaped both by their historical tradition of self-regulation (see chapter 4) and perceptions about adverse regulatory impacts (see chapter 5), the second part of this chapter assesses the monitoring and enforcement regimes that operate alongside attempts to apply EWTD-compliant work strategies. It also explores the key features of the policing mechanisms to determine whether the EWTD represents a primarily symbolic measure, as argued in chapter 6, or whether the legislation is realistically enforceable. The chapter concludes with a discussion on the PRHOs' working hours reported in the study's survey to assess the Regulations' effect at hospital level. Drawing on the literature that explores the cultural aspects of the medical profession (Freidson 1970a, 1970b, 1994; Johnson 1972; Larson 1977) they compare the views of junior and senior doctors and their managers to analyse how each directly support and resist the processes of implementing and complying with the Directive. These contextualised tensions reflect the wider debates on the doctors' increased regulation and the consequent limits on their clinical autonomy (Harrison and Ahmad 2000; Exworthy and Halford 1999; Flynn 1999; Farnham and Horton 1996).

Implementing the European Working Time Directive

Achieving compliance with the EWTD is perceived as part of the larger objective of modernising the NHS (Department of Health 2004). In the absence of state intervention, individual Trusts and their respective managers have been given the main responsibility for implementing the regulations. The lack of centralised involvement in the process raised questions about the ability to apply consistently the EWTD provisions on a broad scale:

> An official circular and that was it. We have not as yet interpreted [the legislation] on a regional basis on how the Directive is going to be applied. There are no consistent approaches.
>
> Medical staffing manager.

State intervention was confined to the funding of a series of case studies and pilot schemes carried out by the Department of Health's Modernising Agency and the NHS National Workforce Projects (chapter 5). Some of the study's informants perceived these strategies, which sought to explore innovative and realistic ways of implementing the regulations, in a negative light:

> The thing that strikes me about the EWTD is how badly it has been managed. The notion of the EWTD was introduced in 1993. We are in 2004 and we are only now getting grips with it. At the best, we are eleven years' behind.
>
> Operating Department Practitioner.

The lack of central guidance, which had led to this apparent discontent, partly resulted from New Labour's rushed passing of the EWTD after what the Deputy Chairman of the BMA's Junior Doctor Committee described as the Conservative government's "stalling process", and its attempt to annul the Directive at the European Court (Chapter 3) with the "hope that the law may be changed or revoked". The minimal intervention by the Department of Health therefore presents a practical ongoing commitment continuing the voluntarist tradition of managing employer-employee relations in the UK underscored by the previous Conservative government, with a legal commitment to statutory limits on working hours (Exworthy and Halford 1999; Dawson *et al.* 1988). However, against the historical backdrop of doctors' self-regulation and the broader laissez-faire approach to market regulation, paradoxically the

study found support among employers and senior members of the medical profession for more state intervention and guidance.

Given the general dissatisfaction with the present state of affairs, the informants were asked about the implementation of the EWTD's stricter limits imposed in 2007 and 2009. The 58-hour working week was perceived by the Senior EWTD policy advisor at the Royal College of Surgeons as an "enormous hurdle to jump" and the Director of NHS Employers was of the opinion that "2009 is a real challenge". Some informants argued that the unanticipated ECJ rulings (chapter 5) had played a part in disrupting the implementation strategies:

> It was *SIMAP* and *Jaegar* that moved the goal posts quite late in the day that made the NHS realise that solutions had to be had.
>
> Acting Director, NHS Modernisation Agency.

A senior EC Commissioner in Brussels predicted that some Member States would make use of the Directive's provision to extend the implementation period beyond 2009. However, the Deputy Chairman of the BMA's JDC believed that this would lead to a "fairly dim view [being] taken wholly on the idea that 'we couldn't do it'". Furthermore, he did not foresee the failure of NHS planning as an adequate reason to take advantage of the extension clause. The focus upon the role of the state in the planning and implementation of the EWTD continues in the next section which discusses the mechanisms to both monitor and enforce the legislative provisions.

Monitoring and enforcement

The Health and Safety Executive (HSE) is charged with the task of ensuring EWTD's weekly limits are observed (chapter 3). Its potential ability to enforce the regulation effectively, however, is compromised by the general absence of a centralised auditing systems to gather data on working time. This task falls to managers within individual Trusts, who are required to monitor the working hours of the junior doctors they employ. This raises a number of questions on how the HSE enforces the Directive's provisions.

The position differs in England and Wales. The results of working-time monitoring in Wales' NHS Trusts are reported to a central source, namely the Welsh Assembly Government

(WAG). The latter currently provides Trusts with computerised templates prescribing different forms of work rotas that allow managers to assess whether or not the way in which they organise doctors' working time is compliant with the EC regulations. Managers have the option to implement these model rotas, and the majority do so. The compliance figures (reported below) routinely published by WAG reflect the rotas at the time of monitoring periods. As a result, compliance or non-compliance is judged by reference to the rotas adopted by managers. The most recent figures, compiled in September 2006, are presented below:

Table 3
EWTD Compliance in Wales' NHS Trust

Trust	F1 Number In Post	F1 Number Compliant	F2 Number In Post	F2 Number Compliant	Flexi Number In Post	Flexi Number Compliant
Bro Morgannwg	23	23	26	26	13	13
Cardiff & Vale	59	59	65	65	32	32
Carmarthen	25	25	30	30	2	2
Ceredigion	9	9	12	12	1	1
Conwy & Denbigh	18	18	18	18	2	2
Gwent	39	39	48	44	18	18
NEWT	18	18	0	0	4	4
North Glam	14	14	15	15	0	0
North West Wales	15	15	17	17	2	2
Pembroke	9	9	9	9	16	16
Pontyrpidd & Rhondda	18	18	10	10	6	6
Powys	0	0	0	0	0	0
Swansea	32	32	33	33	14	14
Velindre	0	0	0	0	7	7
TOTALS	279	279	283	279	117	117

(Source: Junior Doctor Coordinator, Welsh Assembly Government)

This table provides an overview of EWTD compliance within Wales' NHS Trusts between the most junior ranks in the medical profession. 'F1' refers to the first year of the Foundation programme, and 'F2' refers to the second year. This scheme replaces PRHO and SHO programmes that were in place at the latter stages of writing-up this thesis. 'Flexi' applies to those doctors training on a flexible – a less than full-time – basis (BMA 2004e). The statistics

show only four PRHOs (from the F2 cohort) working in excess of the Regulations' limits, and all are confined to the Gwent NHS Trust. They correspond with the findings of a BMA report discussed in chapter 4 which found a corresponding analogy between New Deal compliance and the junior doctors' level of seniority (BMA 2006a). More importantly in this context, both the BMA survey and the WAG statistics reported overall compliance with the Directive among PRHOs in Wales.

The WAG figures, however, should be interpreted with caution as I was told by the Junior Doctor Coordinator at WAG that they do not necessarily reflect the number of hours *actually* worked by doctors. Rather, the table reflects the doctors' working hours that are prescribed in the rotas adopted by their managers. The focus of the monitoring system on reported hours, which are drawn from the rotas, rather than on actual hours may therefore be concealing non-compliance with the Directive. The ultimate penalties in respect of the latter include a minimum six month's prison sentence for the chief executive, minimum fines of £5000 per transgression per week, in addition to the HSE sanctions. However, the Junior Doctor Coordinator explained that it was not policy to conduct further inquiries into juniors' hours beyond the figures reported by managers to WAG, as the issue of general work conditions was essentially an employer/employee matter.

Unlike Wales, at the time of the study there was no central source at all documenting the working hours of doctors in any of the English NHS Trusts. The same was apparent in Europe. The HSE's senior policy advisor confirmed that individual Member States generally were not required to provide statistical information to a central enforcement agency, and that there was no liaison between the European Commission and the Member States on the issue. The state of affairs was therefore characterised by either a lack of centralised data, or systems that potentially did not accurately reflect work time practices:

> Because [the EWTD] is not a policy decision, the NHS does not need to report internally. This would be a matter between the individual trusts and the Health and Safety Executive (HSE). There was some monitoring held prior to August [2004] to ensure compliance, but this is not ongoing.
>
> Acting Director, NHS Modernisation Agency.

The lack of a central agency auditing doctors' work hours therefore calls into question the effectiveness of the current EWTD enforcement strategy. The absence of a single source of accurate data limits the HSE to essentially a reactive role which largely depends on official complaints from junior doctors themselves. Between 1 February 2005 and 28 February 2006 the HSE had received thirteen phone calls vis-à-vis the hours worked by junior doctors, though the confidentiality of this service meant that this figure may only represent a small fraction of actual queries as the enquirers were not obliged to provide any information about themselves or their occupation. The Junior Doctor Coordinator at WAG also suggested that general ignorance about the EWTD among doctors could be attributable to the very few complaints put to the HSE. A senior policy advisor at the HSE commented that the majority of notices it issued under the Working Time Regulations were in relation to unacceptable monitoring processes and poor record-keeping. He had found that NHS Trusts on the whole were supportive of HSE investigations "though some had been less cooperative than others".

This has resulted in a bizarre situation which involves serious potential sanctions for laws which are almost unenforceable. The study's elite informants in chapter 6 initially welcomed the EWTD for its criminal penalties, however the policing resources invested in by the state has significantly diluted the legislation's potential to punish offenders. Together with the absence of independently-audited sources of information about doctors' working hours which are needed to enforce the regulation, the trends reinforce the state's broader voluntarist approach to regulation. Working time and related issues are essentially perceived as matters to be negotiated between employer and employee, which conventionally preclude state intervention.

The process of implementation and compliance with the Directive at a hospital level

The remainder of this chapter explores the relationships between hospital managers and doctors of different seniorities to examine critically the sources of support and resistance to the ways in which the EWTD has been implemented and complied with in practice. The study found that many informants in the medical profession perceived the EWTD as extending managers' authority over their work and personal lives (see also Hoggett 1996) through the wide use of shift patterns involving little or no consultation with doctors. This echoes the trends discussed in chapter 4 about the general ascendancy of managerialism in the

NHS, and the adverse impact on doctors' clinical autonomy (Harrison and Ahmad 2000; Exworthy and Halford 1999; Flynn 1999; Farnham and Horton 1996).

Shift work was generally perceived by managers and doctors alike as the only viable way to reduce junior doctors' working hours. As part of their rotas, most juniors now work full 11- to 13-hour night shifts as opposed to on-call arrangements (NWP 2006). Implemented by managers in most hospitals as a response to the EWTD, it was now commonplace among Pre-Registration House Officers:

> All our building of rotas are set against the best option for the junior doctors we've no option but full shifts for those very junior grades.
>
> Medical staffing manager.

Managers' authority to organise generic shift patterns for junior doctors was further legitimised by the European Court of Justice's broader definition of working time. It was claimed that introducing shift work was the only option to meet the statutory requirements laid down by the EWTD. Allowing managers to organise doctors' working time within these parameters reflected the growing authority of the former on the one hand, and the profession's diminution in influence on the other (Exworthy and Halford 1999):

> Management have more authority over working life. There are more managers than ever now. The EWTD is a managerial job.
>
> Consultant and Professor in Paediatrics.

The implications of increased managerial influence over doctors' clinical autonomy helped to fuel resistance among some doctors towards the EWTD's implementation process (below). Tensions were exacerbated by the managers' lack of consultation with doctors over arranging EWTD-compliance strategies (BMA 2006b). According to the Associate Dean for Flexible Training, many doctors had not been consulted on the planning and implementation of the Directive:

> I think there has been a very mechanistic approach towards [the EWTD's] implementation. A lot of departments haven't involved the individuals who are going to have to work those patterns.
>
> Associate Dean for Flexible Training.

The experience of being omitted from the EWTD's consultation processes was seen by some of the study's informants as part of a broader reflection of how the NHS implemented different strategies affecting the work conditions of its employees. A senior Operation Department Practitioner (ODP), whose work regularly brought him into contact with surgeons, maintained that the NHS' "change overload" often accompanied a lack of explanation, and encapsulated an approach that required its workforce to merely "get on and do the job". The increase in managerial authority over doctors' working and personal lives had consequently formed new tensions and had exacerbated some existing ones between managers and the professionals. There were some differences, however, in the responses given by junior and senior doctors.

Senior doctors

The BMA has outlined how some doctors are "enraged by the proliferation of managers, because managers usually have no understanding of clinical priorities, and their protocols waste precious doctors' time" (BMA 2006b). this study found that the primary source of resistance to the implementation of the EWTD stemmed from senior doctors:

> In trying to implement the policy, the biggest stumbling block has been at consultant level, and its ongoing.
>
> Medical staffing manager.

According to the Medical Director interviewed during this study, complaints by the consultants had principally centred on the inability to have the same set of junior staff working under their supervision for each night and day shift. Some of them circumvented the legislation's monitoring process by harassing individual junior doctors to report EWTD-compliant working time, even if they had worked in excess of the Regulations' limits. This practice had come to the attention of both the Deputy Chairman of the BMA's JDC, and was experienced by one PRHO informant:

> They gave the monitoring forms to the mess president who then gave them to us and asked, "Do these truly reflect [your working hours]?" And we had to decide. We were pushed into saying, "no, they don't reflect. We work less than that.
>
> Dr F.

This was not an infrequent occurrence as several of the study's informants claimed to have had direct or indirect experience of this practice. It was also raised in a report on the initial implementation of the EWTD (BMA 2004b). Submitting inaccurate working time records highlights the possible discrepancy between actual and reported hours, and reinforces the potentially diluted impact of the EWTD. Furthermore, the influence of senior doctors over their junior counterparts underpins the exclusive culture of the medical profession, its close socialisation processes among its members and dissociation with its non-members which facilitate the transmission of ideas on work conditions, and an occupational resistance to measures such as the Directive. This supports the debates contained in the relevant literature in chapter 4 (Sinclair 1997a; Haas and Shaffir 1987; Shapiro 1987).

Some of the long-serving senior consultants had experienced various modes of internal and external professional governance including self-regulation, the New Deal and a supranational form of legislation. For these doctors, their historical modes of regulation helped to foster opposition to the EWTD (chapter 6). The Dean of Medicine referred to a wide disregard among a number of older consultants towards a fixed work time, and the further encroachment of managerial intervention and scrutiny (Harrison 1990a). Many doctors were apparently discontent because their work schedules were not a product of *their* planning or control (BMA 2006b). The growing army of increasingly powerful managers reinforced the continuing trend that decisions on work conditions were not being made by doctors' themselves, or by their representative bodies (Williams 2001; Harrison and Ahmad 2000).

Junior doctors

The junior doctors interviewed for this study voiced fewer criticisms of hospital managers in general, and about the way in which their work was organised in particular, than did their senior counterparts (Greer 2005a). This can be explained by reference to the period in which juniors were undertaking their training. Unlike the senior doctors, newly qualified PRHOs were not accustomed to the debates and complexities surrounding previous modes of the

profession's regulation. The juniors' indifference to working-time restrictions may therefore have been shaped by their lack of a comparative benchmark upon which they could contrast their work conditions to those set under previous forms of regulation. It appears that their only reference point to other work patterns derived from the accounts voiced by senior doctors.

Some tensions among the junior doctors did emerge on issues generally surrounding their working time, but these were principally confined to annual leave rather than working hours *per se*. The interviews with junior doctors presented managers as an anonymous workforce with whom contact was established on individual matters; this relationship tended to shape negative views:

> We don't really know them (Medical Staffing). They are just names on paper. We couldn't get hold of them.
>
> Dr F.

This view depicted a tension that resulted from managers' perceived lack of accessibility and flexibility. Dr E, G and J, for example, described how managers left them with very little choice as to when they could take their annual leave entitlements. Other junior doctors saw managers as a general nuisance whose influence hindered their working conditions, and whose support lacked when disputes arose:

> Medical personnel are very obstructive and intimidating and introduce a lot of paperwork to discourage complaints.
>
> Survey respondent 26.

Thus, both junior and senior doctors concurred that managerial intervention restricted the profession's autonomy to carry out their routine work, in line with their longstanding self-regulating tradition. Chapter 8 will also show how junior doctors are consulted less about their work conditions than their senior counterparts. Some of them saw managers as implementing an agenda to achieve EWTD compliance without giving due consideration to their personal concerns on matters such as medical training, medical services and anxieties on staffing.

Junior doctors were a source of resistance to the process of EWTD implementation, particularly in relation to their inconsistent obligations to monitor working time. This reciprocal duty placed on both junior doctors and their employers was not always met in practice. The differences between prescribed and actual working hours among junior doctors are discussed below to show how patterns of under-reporting working time escapes the attention of management, and undermines the legislation's effect. However, there were also some instances in which junior doctors deliberately over-reported their working hours for material gain:

> Sometimes, it's a deliberate ploy for them to keep their hours high so they'll get monitored at the extra band. There's a perverse incentive built into the system because if they get monitored as working beyond the number of working hours, there are many instances in which they can get paid more.
>
> Dean and Director for Postgraduate and Medical Education.

The medical staffing manager was aware of these practices and argued that while in many cases junior doctors were honest and cooperative, a small number realised the salary benefits of appearing to work longer hours. This, at time, shaped their reporting practices:

> If there is an opportunity to slightly slip outside the regulations, then they will make sure that that's happened.
>
> Medical Staffing manager.

The above NHS trust had consequently formulated a range of disciplinary processes to deter junior doctors from over-reporting their hours. These involved procedures whereby consultants verified the work times recorded by PRHOs. The latter's refusal to cooperate with their monitoring obligations would also result in an official warning.

There were also occasions reported in which managers had been perceived as equally responsible for failing to comply with their obligations to monitor working-time:

> I'm not aware that I'm being monitored. Nobody monitors when you come in and when you go home.
>
> Dr J.

The majority of the PRHO interviewees, however, had received documentation requesting them to record their work hours. Dr E referred to other problems including communication difficulties between management and doctors as to when the monitoring periods were taking place:

> I did mine (monitoring) 3 weeks after. Mine was in my pigeon hole and I didn't check it for 3 weeks and the deadline had already passed. They told me to just backdate them. So, I did them all in one go.
>
> Dr E.

The problems associated with the monitoring processes at hospital level were therefore attributable to the behaviour of both managers and doctors. These factors had combined with the complexities surrounding the lack of state guidance on the implementation of the EWTD on a broader level, to shape uneven EWTD-compliant rates among junior doctors:

> Insofar as we are struggling for compliance – no [we did not adequately prepare for the EWTD].
>
> Medical Director.

According to some of the study's elite informants, the issues surrounding the planning and implementation of the EWTD had therefore limited the impact of the law. The state's response to the Directive was seen as rooted in its traditional approach towards the regulation of working time. This study sought to explore these experiences in more depth by asking PRHOs in Wales to report their working time. The survey found that that the average working week of PRHOs was 53 hours. It identified 20% of respondents currently meeting the 48-hour week requirements that becomes mandatory in August 2009, and 79% complied with the 56 hour week which reflects the August 2007 limits. However, of the junior doctors who responded to the survey, 21% continued to work in excess of 58 hours a week. Findings from both the surveys and interviews revealed that working time was frequently shaped by

the particular medical speciality within which PRHOs were training. Dr E highlighted such differences by reference to her training in surgery, which entailed an eight-hour shift over a five-day period for four weeks followed by two weeks of intense twelve-hour shifts, and her earlier experience in Accident and Emergency that involved shorter shift arrangements. For many informants, these inconsistencies often reflected discrepancies between their actual and prescribed or contracted working time:

> When you look at your hours sometimes, what you're meant to be doing and what you're actually doing are different.
>
> Dr B.

Similarly, Dr C's working time when training in general practice corresponded to the EWTD requirements, but 7pm finishes were the trend in Ear, Nose & Throat; her surgery block included both shifts and on-call rotas, amounting on occasions to 116 hours per week with no protected sleep. Survey respondent 99 reported working 102-108 hours a week during her intense shift periods with additional on-call commitments. Overall, the survey found that 68% of all respondents worked an average of five hours a week over their prescribed hours, with 23% of that figure working more than five hours each time. The Dean and Director for Postgraduate Medical and Dental Education echoed was not surprised by these findings, and acknowledged that the number of doctors who actually worked in excess of their officially monitored time in Wales was between 30 and 40 per cent.

These trends were not replicated among flexible PRHO trainees. They were required to work a minimum 50% of the equivalent full-time training programme, but over a two-year period. In Wales they currently worked between 50-60% of this overall proportion, resulting in an average working week of between 28 and 33 hours. Unlike the work patterns of full-time PRHOs, the Associate Dean for Flexible Training at the Postgraduate Deanery did not identify a general disparity in flexible trainees' actual and contracted working hours, though some exceeded their prescribed hours to complete their PRHO training more quickly. This trend was generally attributable to a funding policy run by the Deanery:

> Even if the part-time trainees are being placed in departments where the full-time trainees aren't compliant, then we can specify that they can only receive funding for part-time training if the posts they go into are EWTD compliant.

Associate Dean for Flexible Training.

The effect of this policy had been two-fold. The findings showed that the EWTD had had a direct impact on the organisation of working time among flexible PRHOs. Secondly, and partially as a result, there had been greater levels of interest among PRHOs in applying for flexible rather than full-time training (discussed below).

With the exception of flexible trainees, the PRHOs' experiences of long and inconsistent working hours reflected some of the broader issues surrounding the monitoring and enforcement of the regulations, discussed above. The dual impact of poor auditing systems implemented and enforced by the state had, according to these findings, allowed some junior doctors to work excessive hours. This experience also reflects managers' inconsistent implementation of the EWTD among different hospitals and NHS trusts. The state's role in maintaining a voluntarist approach towards the issue of workplace regulation, in this context, therefore contributed to the failure to limit the working time of particular segments of the medical profession. Together with the lack of reported prosecutions in light of the Directive's non-compliance, these findings support the symbolic nature of the law (Kuhn 1961). Ambiguously defined and perhaps even deliberately 'fudged' by the state, the EWTD has provided sufficient room for those charged with implementing the regulation to interpret and effect the provisions in such a way that limits the overall substantive impact.

Furthermore, both managers and senior doctors are also responsible for improperly implementing and monitoring the legislation in a manner that corresponds to the spirit of its health and safety rationale, by permitting junior doctors to work variable hours – some of which evidently offend the Regulations' provisions – within the different medical specialities. The experience of inconsistent work patterns among PRHOs had consequently shaped their variable perspectives on the EWTD. Some of them reflected the criticisms of external regulation that were found among a number of the medical elites in chapter 6, drawing upon the perceived demands of the work involved in providing medical care identified in chapter 5:

> [Doctors] are expected to work late, to work on. They have to work on-call. They have to be there eight in the morning and 8 at night.
>
> Medical Student.

This view echoes that which traditionally resists attempts to regulate doctors' labour conditions, in favour of a self-governed work environment free from external restrictions. The survey sought to identify how common these attitudes were among junior doctors by asking them to indicate whether or not they would opt-out of the legislation if given the choice (as is the case for the general labour market). This also aimed to explore the consistency in views between the senior and junior doctors on the issue of EC regulation. The results showed that 56% of all respondents would opt out of the EWTD if permitted to do so, and that 78% who worked excessive hours thought that doctors should be exempt from the EWTD. This suggests that a particular group of junior doctors would choose to work longer hours in the absence of regulation, which paradoxically shows how members of a health-based profession would put their own welfare at risk in addition to that of their patients by working excessive time. Like their seniors, a small proportion of PRHOs viewed the Directive as a constraint on their work arguing, as did the elite informants in chapter 6, that the regulation failed to accommodate the perceived concerns of medical care:

> In a lot of areas you are expected to stay on and be responsible to your patient, finish the job you are doing. In some areas that is appropriate.
>
> BMA Deputy Chairman JDC.

Among other factors, the historical "ethos of medicine" (Dr H) had therefore created an expectation among some junior doctors to work beyond the hours prescribed by managers and legislatures. They were conditioned from the outset to adopt such attitudes while at medical school:

> It goes back right back to when you start Med School. You are segregated by the amount of commitment you're expected to give.
>
> Dr C.

Experiences of long hours in medical school therefore shaped the attitudes of junior doctors, and led to a perceived expectation to such work patterns later on in their careers. These longstanding ideas were nurtured and recycled between different generations of doctors within a typically closed and elitist professional culture (Beardwood 1999; Stacey 1992), whose members shared a common background. This facilitated a process of enhancing and reinforcing collective attitudes towards matters such as legal regulation (Kirk-Smith and

Stretch 2003). On being asked about this culture, the Sub-Dean for Admissions at a medical school related to certain characteristics that were common among many of the medical students' backgrounds. Along with the Head of Postgraduate Recruitment and Widening Access, he confirmed that this profession generally drew applicants from the higher socio-economic classes; this was largely attributable to the expense associated with pursuing medicine at University:

> All the data does show that there are certain groups from social groupings [one to three] that tend to apply. Medicine could be more inclusive than what it is at the moment.
>
> Sub-Dean for Admissions, Medical School.

In addition to the social class from which medical professionals were more likely to be drawn, the Sub-Dean believed that a substantial proportion of medical school applicants came from families within which medicine was already practised. Thus recycling cultural notions of professionalism and regulation can often take place within and outside of the boundaries of medical school and the hospital. The students' and doctors' mutual backgrounds were further reinforced by the intense dual socialisation and dissociation processes which they underwent during their periods of training (Sinclair 1997; Shapiro 1987). Dr C referred to the commitments expected of students attending medical school and its consequential segregation from other university students, and a medical student similarly spoke about the "cliquey bunch" label attached to her course colleagues whose academic and social time was largely spent with each other. In line with the socialisation process among medical students was therefore a concurrent inclination towards dissociation from other 'lay' students (Shapiro 1987; Elliot 1972). These patterns explained why some junior doctors approached issues such as regulation in a similar manner to that adopted by the senior doctors. Certain views were therefore contained and transmitted within a closed and exclusive group.

Despite little over half of the survey respondents indicating that they would opt-out of the Directive if given the opportunity to do so, every PRHO interviewee agreed on the necessity of working to a statutory maximum weekly schedule, and a significant majority of respondents (80%) were of the opinion that doctors should not be excluded from within the scope of the legislation. This was particularly the case among female PRHOs (86% compared to 69% of males) which perhaps reflected their concerns of achieving a good balance between

work and family life during their more senior grades. This inconsistency in outlook reflects the mixed attitudes towards EC regulation adopted by the elite informants in chapter 6. While the prospect of better work hours, health and work-life balance influenced a pro-regulatory school of thought among many of the juniors, the discussions in the next chapter explore facets of the EWTD which they perceived as adversely affecting other aspects of their medical services and training. On the one hand, some of their concerns related to the legislation itself and, on the other, to both the strategies put into place to implement the legislation and the nature of their working environment, neither of which falls within the Directive's ambit.

In response to the resistance to regulation among some of senior consultants interviewed in this study, a number of junior doctor informants argued that regulation was vital to address these longstanding attitudes. Dr C, for example, often came across consultants referring to working-time practices "in their day". A senior staffing manager similarly argued that the senior doctors' cultural ideas impeded management's progress on attaining EWTD compliance:

> The overwhelming views of the consultants are that [regulation on working time] has been unfair; its "inappropriate"; "I have to work seven days a week, so why can't they?"
>
> Medical staffing manager.

The study therefore identified a shared attitude among some of the senior members of the medical profession which believed that today's junior doctors must work long hours simply because this was their experience of medical training. Their reference to the working hours then and now was used to resist regulation. This view was particularly criticised by one informant:

> Medicine now is so different and technological, and the expectations of the people in the community are such that we cannot compare my experience to the house officer's experience [now].
>
> Consultant Occupational Physician.

As noted by the Occupational Physician, it was simply incorrect to compare working time now against the period in which many of the senior doctors trained, because of the changes in the delivery of medical services and training that had occurred over time. Such comparisons, and references to "how things were done in their day" (Dr B), tended to generate tensions between senior and junior doctors. The latter, by contrast, spoke in length about the satisfaction from working far shorter hours:

> I don't think we work too many hours now. I'm quite happy. My hours are good.
>
> Dr E.

Reflecting these thoughts, both the Consultant Surgeon and the Deputy Chair of the BMA's Junior Doctor Committee recorded fewer complaints by junior doctors nowadays about their working time, poor health and an ill-balanced work-life. These overall views amounted to evidence of more tolerance among juniors than their seniors towards external regulation resulting, possibly, from their lack of experience of any other mode of work organisation. The Dean of Medicine, a consultant whose work remit oversaw the general welfare and teaching of all Medical School students, identified this shift in outlook among the younger consultants:

> I think what you will find these days are that most consultants, particularly younger ones will not expect you to stay.
>
> Dean of Medicine.

Both the Consultant Occupational Physician and the Chief Medical Officer at WAG also argued that the long hours' culture was adjusting alongside the evolving attitudes among younger generations of the profession. Such changes are significant insofar as they illustrate the developing nature of the medical profession generally, and its particular expectation to work excessive hours. The profession is consequently facing internal divisions and inconsistencies on the issue of regulation, with the majority of the senior generations on the one hand advocating a retraction from EC governance to forms of self-regulation and New Deal arrangements (chapter 6), and a significant proportion of junior doctors, together with some younger consultants on the other, supporting highly centralised state regulation (Greer 2005a). Together with the wider evolution of the medical culture, the fragmentation of the medical community's outlook on external regulation, evidenced by the junior doctors'

attitudes that generally tolerate shorter working hours in compliance with the EWTD, has meant that collective opposition to the legislation is perhaps not strong enough to prevent the implementation of various management-led approaches that aim to secure compliance with the Directive's requirements. In broader terms, this reflects the ascendancy of managerialism and the adjusted dominance of the medical profession over policymaking and the administration of medical care (Williams 2001; Harrison and Ahmad 2000; Berg 1997; Strong and Robinson 1990).

Supported by its criminal sanctions, the EWTD may have had a restricted role to play in these changes insofar as it has highlighted the need to reduce the working hours of doctors in line with the rest of the labour market. It had consequently led managers and the profession to consider implementing approaches that tackle the long hours' culture. The Chief Medical Officer, along with other informants, explicitly attributed some of these general patterns and attitudinal trends to the Directive:

> I think [junior doctors' working hours] have definitely come down as a result of the EWTD. That's what has brought the impetus.
>
> MEP, Labour.

The data pointed towards a general trend of shorter working hours among junior doctors, which had been facilitated by management's wide use of shift systems. However, these patterns may have been part of a longer trend; the symbolic and substantive impact of the law is discussed in more detail in the study's conclusions.

Assessment

Hospital Trusts were apparently ill prepared to implement and enforce the EWTD within this context, which consequently highlighted the role of the state in the broader process. It affirms the generally voluntarist nature of employment relations which continue to govern the conditions of work in the UK labour market (Dawson *et al.* 1988). This trend also demonstrates the ambiguous approach adopted by both the state and the medical profession towards the Directive. The absence of unambiguous standards has left doctors and their employers to shape the legislation's implementation in a way that accommodates their

respective concerns over the criminal sanctions for non-compliance on the one hand, and the perceived impact of the regulation on medical training and service on the other.

The views on the regulation have therefore highlighted a tension in the different priorities and concerns encapsulated by both management and the medical profession. Chapter 6 showed how, on one view, the anxieties of managers over the imposition of criminal sanctions had compelled them to introduce shorter hours for junior doctors. It might be argued that the use of such punishments can achieve compliance far more effectively than with conventional regulation whose enforcement techniques are characterised by advice, persuasion and negotiation (Gunningham and Grabosky 1998). This was largely the position under the provisions contained within the doctors' New Deal. Chapter 6 showed how the differences in sanctions underscored the distinct approaches adopted by managers towards New Deal and EWTD compliance.

However, this line of argument is, to an extent, flawed by the EWTD's enforceability. Both the widespread non-compliance among the majority of Member States identified in chapter 6, together with the inconsistent patterns of compliance among PRHOs in Wales discussed in this chapter has made the European Commission's possibility of initiating proceedings against individual hospital chief executives unrealistic. Thus, it could be argued that the primary impact of the EWTD therefore derives from the symbolic element of the law discussed in the previous chapter (Yaegar 1991; Kuhn 1961), given that the actual prospect of prosecution is unlikely. The contrast between the potential seriousness of the sanctions, and the actual practical possibilities of applying them in the absence of proper audited central records of work hours, therefore raises some serious questions about the regulations' enforceability (Allot 1980), and particularly what kind of evidence could be possibly marshalled in a criminal prosecution under this type of law (Yaegar 1991).

The concerns voiced by the medical profession on the EWTD in chapter 5 were not influenced by the legislations' sanctions, but rather on the perceived impact of regulation on junior doctors' health and work-life, and medical training, staffing and services. The process of implementing the EWTD has therefore illustrated the different interests at stake, and the influence of professional cultural factors in this socio-legal interaction (Gunningham and Grabosky 1998; Gunningham and Rees 1997; Makkai and Braithwaite 1993; Grabosky and Braithwaite 1986; Kagan and Scholz 1984). On the one hand, managers and senior hospital

staff had been charged with the responsibility for organising these patterns of work in the general absence of state guidance. On the other, doctors' service and training were required to accommodate this organisation of working time with little consultation. These points of contention have exacerbated the working relations by elevating the managerial prerogative over the way doctors can pursue their clinical work inside and their personal life outside the hospital environment. The strains of this relationship were highlighted by a number of informants.

Some of the views held by both junior and senior doctors and their managers indicated a broader and consistent tension between the medical profession and their employers (Hunter 1994; Buchanan *et al.* 1997; Beardwood 1999; Flynn 1999). Nevertheless, the findings identified contrasts between the juniors' experiences under the EWTD and those of the senior doctors (Greer 2005a). The variable experiences between junior and senior doctors, and the fewer complaints among the former about the implementation of the EWTD lays the ground for possible tensions between the way in which different members of the medical profession perceive the impact of the Directive in chapter 8.

Conclusion

These findings illustrate how the state's historical minimal intervention in labour market regulation has resulted in a weak enforcement regime charged with the responsibility to oversee the NHS managers' process of implementing and monitoring the EWTD. The absence of clear and consistent national guidance and frameworks, arguably in line with the legislature's intention to implement an ambiguously defined regulation (chapter 6), has also adversely affected the legislation's application and compliance rates at individual hospital levels. Assessing the degree of irregularity across Britain is, however, hindered by the lack of centrally-held and audited sources of information. The position is slightly different in Wales, but even the reliability of data here is not sufficiently strong to draw credible conclusions. This poses some significant questions about the general enforceability of the criminal sanctions contained in the measure – a factor upon which the majority of elite informants in this study based their initial support for the Directive (chapter 6). The contrast between the potential seriousness of the sanctions that could be applied to those who do not comply, and the actual possibilities of applying such sanctions given that there are no properly audited central records of working hours, suggests not only does the lack of evidence limit the

possibilities of (successful) criminal prosecutions, but that the authorities are turning a 'blind eye' to regulatory non-compliance. This issue is further addressed in the study's conclusions.

In the context of a Directive whose monitoring and enforcement mechanisms are to an extent flawed, which has arguably affected the degree of compliance and non-compliance within a sample population of junior doctors in Wales, the next chapter further explores the variability among senior and junior doctors' responses to the regulation, working from some of the differences and similarities identified in this chapter. Fewer complaints about the process of implementing the Directive were voiced by juniors, but the findings recognised a shared concern over managers' intervention in their working lives. As members of the same profession, will they perceive the EWTD itself in a similar way to which they see the process of implementing the legislation? Will the Regulations' impact mean the same to the senior doctors as it will to the junior doctors? These issues are explored in the next chapter.

Chapter 8

The impact of regulating working hours

Introduction

This chapter explores the impact of regulating working time on the work and lives of junior doctors, with specific reference to the European Working Time Directive. It does so by analysing the claims made by both junior and more senior members of the medical profession as to the impact of the legislation on their life within and outside of work. Their claims, based on the personal experiences reported in the surveys, interviews and electronic diaries are thematically organised under the topics of health and work-life, medical training, and medical staffing and services.

These discussions build on the key themes identified in the literature reviewed in chapter 5, in particular the perceived impact of the legislation on different aspects of junior doctors' work and lives. This chapter will therefore examine whether the most junior sector of the medical profession regard what they see are the effects of the EWTD in the same light as their senior counterparts. This analysis draws out the variations between the senior and junior doctors' experiences on the Directive's implementation by the widespread use of the shift system and inconsistent patterns of compliance, discussed in chapter 7. This theme is further developed in this chapter to assess the degree of contradiction between different members of the medical profession, and to consider the implications in terms of how the regulation is perceived.

The chapter sets out the claims upon which the junior doctors' support and oppose the Directive in a fashion similar to the discussions which sought to identify the perceptions of the elite informants in chapter 6. The differences between both groups, however, may presumably be shaped by the juniors' lack of experience of their profession's previous modes of regulation described in chapter 4. For them, conditions of work have not altered as a result of the EWTD. They are unaware of any other forms of work regulation or working-time organisation using shift patterns, except for the references made by senior members of the profession who have had such experiences. The senior doctors' views about the tensions surrounding the regulation of their work provide a contextual focus for the findings related by junior doctors. It is a key reference point within which they operate, and is reinforced by the closed and exclusive nature of the medical profession within which certain ideas are

transmitted between generations of doctors. Chapter 4 identified this source as a particular problem in regulating the profession, and the discussions in this chapter explore the significance of this phenomenon in the context of the EWTD's impact. The chapter therefore addresses the third research objective by attempting to analyse the apparent impact of regulating working time on the work and lives of junior doctors.

Junior doctors' health & work-life

One would assume that the impact of the EWTD on the health of junior doctors would be significant in light of its regulatory objective under article 118a of the Treaty of Rome to improve workers' safety and health by prescribing maximum working hours. The survey, however, identified ill health among the PRHO respondents before and after the regulations' implementation. They both ascertained which symptoms of poor health (if any) the respondents believed were attributed to long working hours. These findings are presented in table 4:

Table 4
Poor health as a result of long working hours

Symptom	***All survey respondents (%)***
Exhaustion / Fatigue	70.5
Stress	56.1
Tension	44.6
Anxiety	41
Headaches/Migraine	32.4
Insomnia	29.5
Weight loss	28.8
Mood symptoms	28.8
Emotional Distress	22.3
Depression	9.4
Suicidal thoughts	2.9
None	8.6

Exhaustion and/or fatigue represented the most commonly experienced symptom which the survey respondents attributed to long working hours, but the overall instances of psychological distress – stress, tension, anxiety, emotional distress, depression and suicidal thoughts – far exceeded this. These findings reflect many of the empirical studies focused on the general health/hours relationship in addition to the specific literature on doctors' health discussed in chapter 5 (Beswick and White 2003; Kodz *et al.* 2003; Kapur *et al.* 1999; Sparks *et al.* 1997; Spurgeon and Harrington 1989; Firth-Cozens 1987). On the one hand, this suggests that the EWTD, as a health and safety regulation, is crucial for the improved welfare

of junior doctors. On the other, the very fact that the junior doctors were reporting these symptoms after the implementation of the EWTD implies that the regulations' impact has thus far proved minimal. These findings suggest that the Directive, ambiguously defined and inconsistently applied as a result, has failed to implement changes which correspond to its primary health objective. It is thus arguable that the continued discontent among those being regulated in reality affirms the role of the legislation as playing a more symbolic function.

Overall, women doctors were characterised as reporting poorer health than men, with the exception of tension (47% of men experienced this compared with 43% women). However, it does not necessarily follow that men suffer less than women. In fact, more men than women in the first cohort reported that they experienced higher levels of exhaustion/fatigue, stress, tension, mood symptoms and depression. Other conditions not included in table. 1 emerged in the interviews and survey responses which were similarly perceived as resulting from working long hours. They included eating disorders, weight loss, difficulties in sleeping, sickness and dermatological problems:

> Many people, my friends in particular lost loads of weight, couldn't sleep and were really clinically depressed. Most of the girls say if you want an instant diet, go get a house officer job!
>
> Dr C.

Survey respondent 101 had experienced suicide thoughts "once after a weekend of 45 hours in three days". These findings accord with national mortality statistics for members of the medical profession:

> You would find that the standard mortality ratio is higher in doctors than in other groups.
>
> Consultant Occupational Physician.

Caution should be taken in interpreting this data as the experiences of poor-health were self-reported, and their degree was subjectively measured. The consistency in defining each symptom of ill-health was more reliable given that the respondents diagnosed such illnesses as part of their everyday work. Nevertheless, the subjectivity associated with the self-

reporting method potentially raised questions about the variability between respondents' individual tolerances to poor health. Methodologically, the survey's limitations mean that the data cannot be interpreted as providing an authoritative measurement of the specific impact of the EWTD, but the findings provide a basis for informed speculation about the effects of the regulations' implementation and the general relationship between work time and health.

Partly as a consequence of their poor health, the PRHOs' careers were being adversely affected. Some of them, for example, had delayed their GMC registration for reasons related to their apparent lack of experience and clinical exposure in medical training, but the Dean and Director for Postgraduate and Medical Education also acknowledged that a small number delayed their registration because of sickness. Dr G, a PRHO training on a flexible basis, had contemplated on withdrawing from medicine completely as a result of stress. These types of experiences, reiterated by the consultant occupational physician, were shared among other junior doctors:

> I know a few of my friends who have dropped out, and a house officer I knew in [*city hospital*] has just dropped out [he had] had enough the hours they were made to work.
>
> Dr F.

There was a small percentage of newly qualified doctors who were not therefore accredited at the end of their PRHO training period with the GMC on grounds that work conditions had resulted in poor health and sickness. Some of the elite stakeholders, however, argued that the stressful nature of working in a hospital environment was often the source of such illness (chapter 6), thus portraying the hours/health interaction as necessitating consideration of the broader environmental, organisational and individualistic factors which have a role to play.

The study's focus on doctors' health within the context of regulation had revealed some interesting paradoxes in line with conclusions drawn from other research (Cartwright *et al.* 2002; Moss *et al.* 1996; Firth-Cozens 1987; Firth 1986). The first paradox related to the general experience of illness among those who are themselves charged with providing medical care, and who were also working within the limits prescribed by a health-based Directive. Half of the respondents who reported experiences of poor health chose to work longer hours (50%), and almost half of these respondents would have liked to see doctors exempt from working-time regulation altogether (42%). The second paradox related to the

PRHOs' general unwillingness to take time off work (72%, with no differences reported between males and females). Dr G summed up the reasoning underpinning this trend:

> I feel guilty about it (taking time off work). Last year I had the flu and was actually sick at work, but felt guilty about taking time off, letting down my team.
>
> Dr G.

The majority of informants echoed Dr G's concerns by referring to the importance of team support despite sometimes being ill at work with conjunctivitis, the 'lurgy', physical sickness and even a broken arm! The findings therefore showed how PRHOs, unwilling to take time off, yet experiencing such symptoms, consequently exposed illnesses not only to other members of the team upon whom they felt they could not 'let down' in the first place, but also to the patients whose welfare was their professional concern. These paradoxes could be explained by what this study identified as a 'coping culture' among members of the medical profession. This is an expectation which considers doctors to be immune from poor health by the very nature of their occupational roles (Cassidy and Griffiths 2004). In attempting to maintain this representation, doctors were "expected to grit their teeth" (Consultant in Paediatrics) and "to simply get on with their work" (Dr B):

> There is certainly an expectation that you will be able to cope with it. Most people do cope, and your time and experiences in your studies makes you realise what is expected of you. But then sometimes, there are a few who find it more difficult and often stressful.
>
> Consultant Surgeon.

The so-called coping culture raised the issue of support and help for those doctors experiencing difficulties. Rather than seeking professional advice and using the appropriate (and legal) channels, some of the study's informants had reported self-prescription among a few doctors as part of their coping strategy (Forsythe *et al.* 1999; Baldwin *et al.* 1997*b*; McKee and Black 1992). The occupational physician had been approached on several occasions by consultants and other doctors in their latter years of training for medication to 'cope' with the effects of work. In his experience, doctors often did not resort to consulting a GP simply because they found physically accessing one did not coincide with their work patterns. These access difficulties were exacerbated for PRHOs whose training periods

involved moving around different hospitals and specialties over a short term. Doctors also avoided visiting their GPs for another reason:

> There may be subconsciously a desire to avoid certain diagnoses, not to face up to their diagnoses and to consult with somebody whose going to make a diagnosis that you don't want to hear.
>
> Consultant Occupational Physician.

Self-prescriptions and self-referrals were, according to the PRHO informants, confined to the senior members of the medical profession, and doctors E, F, and G had all authorised the prescription of medication for those in their latter stages of training.

A proportion of the study's informants perceived the EWTD as potentially delivering a better work-life balance by reducing their time spent at work. The latter has been explicitly linked with various health effects (Allen 1994). The general EWTD's phased reduction in doctors' hours had resulted in little over half (56%) of the survey respondents being satisfied with their work-life balance, more so among men (59%). PRHOs maintaining their actual working hours were more satisfied (80%) compared to those who worked over their prescribed hours (46%). The findings therefore identified a corresponding analogy between working hours and work-life satisfaction: the fewer the hours worked by junior doctors, the more satisfied they were with their work-life balance. For those working 48 hours a week, 82% were content, compared to lower satisfaction levels among PRHOs working longer hours (63% and 61% of respondents reported satisfaction if they worked a 56-hour and 58-hour week, respectively). The reduction in hours, facilitated by the EWTD, therefore underscored the regulatory impact on the lives of junior doctors spent outside their working environment:

> For those who consider their health, work-life and extra commitments to be important, the Directive is a God send!
>
> Dr H.

Conversely, this attitude illustrated the general dissatisfaction with long working hours. In line with the literature (Evans *et al.* 2004; CHI 2004), the junior doctors' tolerance of external

regulation was partially driven by their preference for a better work-life before job commitment:

> People must realise that doctors are not robots. You can't re-power them in thirty seconds. We are human beings. We are entitled to a life. That's why hours should be reduced – to be in keeping with the quality of life like other people in society.
>
> Dr C.

The overall findings depicted a broader tension between the views generally held by junior doctors nowadays and the longstanding professional ethos which, characterising the outlook of many senior doctors, underpinned the way in which medicine has been traditionally organised. On the issue of work-life, many of the juniors who were interviewed questioned why medicine should be considered any different to other sectors in the labour market. The desire to standardise work conditions reflected the perceived unequal treatment among the younger doctors in the profession compared with general workers. This point of view clearly contrasts with the opposition voiced by the elite informants in chapter 6. The ambiguity surrounding the fundamental terms of the Directive permitted them to shape a similarly vague approach to the Regulations' implementation and compliance, which ultimately limited the impact of the legislation.

Some juniors, however, continued to share the views of their elders, but not for reasons influenced by the broader ideological debates surrounding the regulation of their labour conditions. Rather, the findings of this study suggest that some perceived the reduction in working time brought about by the EWTD as impinging on their salary and as aggravating both poor health and work-life. First, the issue of salary was important to all PRHO informants, particularly given the expense of attending medical school, a later commencement in the labour market compared to other graduates, and the perception surrounding the reduction in working hours as a means of curtailing their earning potential. The survey therefore asked the following question:

> 5.5 Would you work longer working hours if your salary and/or overtime payments were substantially increased?

Only a slight majority (56%) of the respondents stated that they would work longer hours if they were paid more; this was greater among men (65%) than women (50%). Those working shorter hours – up to and including 48 per week – were willing to work for longer periods accompanied by a corresponding salary (63%), whereas PRHOs working above a 48-hour week did not share the same view (51%). This response may have been shaped by an assumption that a higher salary would not compensate for more time spent at the workplace. More respondents who desired longer hours with a better salary predictably resisted the EWTD (71%). Doctors E, F and G, for example, expressed a preference to work longer hours with a corresponding income, and each of them intended on undertaking locum work, suggesting that they saw working-time regulation as a form of limiting their capacity and choice to earn:

> It is important that people have a choice to work longer hours. Having a previous degree/single/no kids/£4000 debt. I want and have to work.
>
> Survey respondent 88.

These attitudes fit in with the broader criticisms made by senior members of the medical profession in chapter 6 that regulation, by its very nature, imposes restrictions on certain aspects of their individual autonomy. Against a historical backdrop of self-regulation, the data gathered from the study's elite informants showed how external intervention in the form of the EWTD had given rise to some strong tensions. These corresponded with the debates in chapter 4 which describes how the clinical autonomy of doctors has been gradually restrained over time through the ascendancy of both managerialism and statutory control by the state (Hunter 1994). As a result of the ECJ's more specific intervention the informants reverted to support the New Deal arrangements. In this instance, the issue of salary underpinned some of the junior doctors' discontent with the constraints associated with the regulation. The importance of salary as a factor shaping concerns about the regulations should not, however, be over-stated. Very few informants opposed the EWTD on the basis of salary simply because the study explicitly found that more doctors preferred a better work-life balance (see above). Furthermore, the anxieties surrounding the impact of reduced hours on salary were largely resolved by the new pay structure negotiated between the BMA and the Department of Health in 2000 (see chapter 5).

Secondly, chronic fatigue and exhaustion, brought about by intense shift work and an accumulation of both insufficient sleep and inadequate recovery periods meant that individual doctors "adjust to just not ever having enough sleep" (Dr A):

> After the end of the two weeks on shifts, you feel physically exhausted. You could work 100, 120 hours. You have no life. You literally go to work, go home and sleep again.
>
> Dr E.

Paradoxically some junior doctors were experiencing the opposite effect of what the Directive had set out to achieve, and this was reflected in their ongoing poor health identified by the surveys. The implementation of shifts was producing levels of fatigue and exhaustion that were, according to the RCS, analogous to "permanent jet lag". Their effects were illustrated by three individual accounts by the PRHOs of separate road traffic accidents which occurred on junior doctors' return from hospital after working intense shifts having had little opportunity to rest. Coincidentally, a PRHO and personal friend of the author was also involved in a car accident on his return from a night shift at the hospital. The doctor recalled falling asleep while driving, and simply attributed the incident to such an overwhelming state of fatigue accumulated over a period of intense shift patterns. Thus, the methods of implementing the welfare-based Directive have ironically led, in a number of instances, to a worse state of health among some junior doctors:

> My own view, as a clinician, is that we have not done anything to improve the well-being of the doctors in training. The way the working patterns have been structured with blocks of long days or blocks of night shifts is much more difficult to adjust to doing four nights in a row than in the past when they did one 24-hour shift.
>
> Associate Dean for Flexible Training.

In spite of the reductions in doctors' excessive working hours, these experiences suggest that the shift system has diluted the potentially significant impact of the EWTD on junior doctors' health and work-life. The discontent associated with this aspect of regulation, however, can be attributed to the failure of the medical profession to respond to the EWTD effectively and in line with the needs of its own members. By attempting to address juniors' working time through the implementation of generic and monolithic shift work, the profession and hospital

management have lacked the necessary innovation to apply more appropriate systems that accommodate the specific concerns voiced by the profession.

This chapter has thus far focused on the experiences of junior doctors under the EWTD regime. These discussions have highlighted some of their variable views, particularly on the necessity of regulation and on the perceived impact of the Directive on their health and work-life to a smaller extent. It is argued that the different facets of their work and individual life experiences have fuelled some of these inconsistent views. The following sections focus on certain aspects of the work carried out by junior doctors. They consider medical training and medical staffing and services. It is necessary to explore these different contexts as they shape and underpin their responses to the regulation. As a result, the findings should identify the consistencies and contradictions between junior and senior doctors. These draw upon the similarities and differences in attitudes discussed in chapter 7 on the issue of the EWTD's implementation and compliance. The significance of the shift system is therefore again explored in the following sections, but in more depth within each of the juniors' facets of medical work.

Medical training

Medical training is important for two reasons. First, it has provided the medical profession with a monopoly over expert knowledge unrivalled by other professions and which has subsequently permitted doctors to influence policymaking in health care and its generally elite position in the labour market (Beardwood 1999; Coburn 1993; Larkin 1993; Stacey 1992; Freidson 1970a, 1970b). It is from this basis that the profession was permitted clinical autonomy and the authority to self-regulate the activities of both itself and the provision of medical care (Furst 1998). Secondly, the issue of medical education is particularly important for doctors who are currently undertaking their training within the working-time restrictions. The need for prolonged clinical exposure and hence long hours has traditionally been motivated by such factors as confidence to practice and career progression. The essence of regulating working time was therefore inevitably seen as restricting these aspects of medical training:

> There is an awful amount of unrest in relation to the way [the EWTD] has been implemented...gross reductions in exposure of training times and exposure to trainers; gross reductions of experience in outpatient's clinics in the operating theatres
>
> Chairman of EWTD Steering Group, Royal College of Surgeons.

For some junior doctors, the EWTD was seen as negatively affecting their ability to undertake the necessary service and education which met their professional expectations. The survey and interview data from PRHOs highlighted three anxieties in particular regarding junior doctors' medical training. Each example was reflected in the literature in chapter 5 (for example, Mather 2004; Sim *et al.* 2004; Scallan 2003; Williams and Cantillon 2000; Alkhulaifi *et al.* 1995), and rested on the premise that the Directive impacted negatively on this feature of their working lives. Each one, however, is susceptible to the alternative argument which focuses on the lack of creativity by elite stakeholders to implement more appropriate work patterns in response to the EWTD. This study does not aim to put forward a comprehensive set of proposals on alternative work strategies to implement the Directive, but suggests some possible options in the relevant sections of this chapter, and in the study's conclusions.

The first of the PRHOs' concerns related to the replacement of on-call arrangements with shift systems:

> When I was doing Medicine, the day-to-day stuff you are not really learning anything. What you learn, you learn when you're on-call.
>
> Dr C.

Given the dependent nature of patients on junior doctors' medical training and experience, Dr C found that her clinical exposure at atypical times of the working day were of most benefit to her training. Dr B concurred, and simply stayed on beyond her work hours for similar reasons:

> If the patient is sick and they are doing procedures, sometimes you stay from that point of view, because that's the only time you're going to see it and that you're going to be taught it.

Dr B.

These responses were reflected among a substantial proportion of survey respondents who believed that training in both medicine and surgery in particular afforded them with essential opportunities to learn about the various clinical procedures but that would not usually occur in a routine day or weekly shift (Shabbir *et al.* 2005). The EWTD was therefore viewed as restricting their ability to train outside the time prescribed in their working patterns. However, the regulation contains no reference on how the medical training is to operate under fewer working hours. This is a matter for the medical profession to resolve by organising an adequate training programme that covers different times of the day, thus protecting junior doctors under the EWTD provisions whilst retaining the benefit of caseloads at atypical times to enhance their training.

The PRHOs' second concern was linked to the perceived impact of the Directive on the reduction of available time to attend educational classes and seminars (Sim *et al.* 2004; William and Cantillon 2000):

> [I] Have hardly attended any [classes]. Clashes with clinics/ward rounds and generally busy job – I get hassle then from Postgrad saying I'm not attending enough sessions. By far the annoying bloody thing is I want to go to learn!
>
> Survey respondent 88.

The working-time restrictions were seen as frustrating some essential aspects of medical learning, but this study argues that these tensions between service and education have nothing to do with the EWTD. It is for both the hospitals, as employers, and the profession to accommodate the junior doctors by organising time effectively for service on the one hand, and for education on the other. Structured timetabling would therefore seem to resolve some of the apprehension surrounding missed classes. The profession should therefore explore beyond the boundaries of conventional training methods to situations which can sit side by side with unexpected 'service' caseloads. The primary example is e-learning; the National Workforce Projects (NWP) has continued the work initiated by the Modernisation Agency into looking at the use of technology amongst other implementation strategies to facilitate junior doctors' training under the EWTD (chapter 5). It is hoped that such changes to the

timetabling and delivery of education will allay some of the anxieties of doctors who currently experience difficulty in juggling their service and training commitments.

The third and consequential concern voiced by junior doctors on the theme of medical training surrounded their confidence and competence to clinically perform within a working environment which had seen a reduction in their exposure time (Shabbir *et al.* 2005; Kapur and House 1998). This was summarised by a Plaid Cymru AM and GP:

> Because of the restriction in hours, (a) they do not appear to be as confident and, (b) as well-trained 'in the business' they know they are inexperienced. They are also relatively inexperienced to consultants of previous generations who had spent thousands of hours in training, and these have got there with hundreds of hours of training
>
> AM, Plaid Cymru.

Such an approach reflected the views of many of the senior consultants, however this reasoning is flawed on two fronts. First, it was not supported by any substantial evidence; the available literature and studies have not conducted competency tests to ascertain levels of confidence and capability following the EWTD's implementation. Such tests would in any case raise some serious methodological questions on measuring a factor like competency between two periods of time, during which the doctors' working environment has significantly changed. Secondly, and related to the latter point, the claim was based on a perception which reverted to the patterns of work carried out almost two decades ago, and even longer in some instances. Basing arguments on experiences at a workplace with minimal regulation years ago is not sustainable in the comparably regulated modern context.

The survey showed a more significant impact on the organisation of working time among flexible PRHOs than their full-time counterparts owing to the funding arrangements which were in place if regulatory compliance was achieved (see chapter 7). The Associate Dean for Flexible Training, responsible for overseeing flexible training at the Postgraduate Deanery, had anticipated the demand for flexible training posts to decrease in line with the working hours of full-timers brought about by the Directive. In contrast, she found that the exact opposite was occurring:

> The EWTD seems to be driving people into part-time work because they don't like the shift patterns of the full-time workers.
>
> Associate Dean for Flexible Training.

As a result of the criticisms associated with the implementation of the shift system among full-time PRHOs, considerable interest had therefore mounted in favour of flexible training. However, the Deputy Chairman of the Junior Doctor Committee at the BMA argued that while there was "a lot of rhetoric about flexible training and flexible employment", the number of flexible training posts in the NHS had not, in fact, increased in proportion to the demand (BMA 2004*c*):

> Flexible working has become in the last few years less flexibly than what it is meant to be...there are people who are in Medicine and would like to work part-time, but they haven't even bothered applying for it because they don't think they'll get it, and there are others who have left Medicine because they can't find the part-time jobs.
>
> Consultant in palliative care.

Failure to address the issue was, according to this informant, having a detrimental effect on recruitment and retention of doctors which was of particular concern in light of the rise in the number of female medical students who would later be entering the profession and seeking more flexible training options[6]. The responsibility to fund such posts in order to meet the current and future demand rests with the state. Its reluctance to increase the intake on a more substantial level arguably reflects its policy of healthcare rationalisation in this particular area (chapter 3). Places at medical school require the same amount of state funding irrespective of whether the students intend to train on a full- or part-time basis. It is therefore not in the interests of the government to later fund PRHO training on a flexible basis when considerable investment was put into educating potentially full-time PRHOs. Responsibility for the discrepancy between demand and opportunity for flexible training also rests with the medical profession and hospital managers. Discussions in this chapter have highlighted their lack of innovation in arranging more flexible work systems (for those working in a full-time basis) that comply with the Directive's requirements. It was also argued in the assessment in chapter

[6] Unfortunately, the survey did not ask respondents to indicate whether or not they would have opted for flexible training had it been made available.

6 that it was not in the interests of the medical profession to expand on its membership. The problems of the current situation were exacerbated by adverse cultural notions:

> Not every consultant supports part-time work.
>
> Dean of Medicine.

The reason underpinning some of the consultants' reluctance to endorse part-time training was related, according to the Dean of Medicine, to the absence of a consistent and full-time 'medical team'. These views are echoed in some of the literature detailed in chapter 5 (North West Wales NHS Trust 2002), but they are arguably the product of the shift system in addition to ongoing strategies comprising multi-professional teams (discussed below). The current work patterns preclude PRHOs' presence at the hospital and the approaches to incorporating more non-medical professionals into the healthcare team illustrate the general move away from the conventional 'medical team.'

In line with the literature (Allen 1994) some of the junior doctors also held reservations about flexible training but for different reasons than those voiced by their seniors. Their anxieties firstly surrounded the consultants' negative perceptions on flexible training, supporting the concept of recycled ideas from within a closed and elitist professional community (Allen 2005). Secondly, with the exception of Dr G, the PRHO interviewees concurred that training part-time was "practically impossible and very inflexible" (Dr A). The prolonged training period (spread over two years rather than one) was seen as being of a lower quality than the full-time programme:

> If I was doing flexible training, I'd be worried that I wouldn't be getting the training because it's not crammed enough.
>
> Dr F.

These concerns were therefore based on the view that training spread over a longer period would result in both less time spent at the hospital and less clinical exposure, and suggests that doctors undertaking training on a flexible basis would not necessarily cope as well if confronted with a full-time model. This view was shared by some hospital managers and personnel. The WAG's Chief Medical Officer acknowledged that certain trusts continued to

take a dim view of flexible trainees, and that this sometimes transpired in their decisions whether or not to employ them (EOR 2003; BMA 2001). Dr G, a part-time PRHO, had gained direct experience of this discrimination:

> I have had a few problems in applying for SHO jobs. I went for one job in *(named a hospital).* I didn't get it, and I went to ask why. One of the reasons, they said, was because I had worked part-time they didn't think I would be able to cope with a full-time SHO job.
>
> Dr G.

The Dean of Medicine, in his experience, had also found that some hospital trusts were "not necessarily as positive". The overall response could be attributed to the failure of the medical profession, hospital managers and the state to respond to the EWTD effectively and in line with the needs of junior doctors. The Chief Medical Officer was, however, optimistic that the general negativity surrounding the work of junior doctors working on flexible rotas would soon dispel with the implementation of the EWTD. She was of the opinion that the widespread operation of a shift system among full-time PRHOs would gradually reduce their working hours in line with the Directive's phased implementation almost to the same weekly hours as those on a flexible basis, thereby putting them all in "the same bucket". The minimal difference in work hours between the two cohorts would, in her view, challenge such assumptions that flexible trainees are less able to cope than their full-time counterparts.

Both full-time and flexible PRHOs judged the quality of their training as variable, depending on factors such as their particular supervisor/consultant, their speciality and hospital. These findings are in line with those contained in the literature (Scallan 2003). Many of the junior doctors spoke at length about what they perceived as aspects of their training and service requirements which were both unproductive and a poor use of their working time (Bogg *et al.* 2001; Lambert *et al.* 2000). Dr E labelled PRHOs generally as "gophers" while Dr C's jobs were sometimes described as "crappy". The latter included answering relatives' questions on whether or not a particular patient had received a brain scan, searching for beds, finding notes and portering. Taking blood and collecting X-rays were among other responsibilities that did not particularly benefit the junior doctors' training:

> I feel like a secretary sometimes. I do a lot of paperwork and filing. There could be a quicker way of doing this.
>
> Dr F.

Dr B often found herself spending too much time on "a lot more jobs like mundane paperwork, rather than learning stuff we may have done five, ten years ago when our hours weren't so restrictive". Comments taken from two Dictaphone diaries also revealed specific differences in the quality of training. Dr E felt particularly frustrated during her shift owing to a consultant arriving very late and she felt as though she had not "really had any teaching at all" on that day. Dr F, on the other hand, was notably satisfied with the levels of exposure and teaching that she received and considered herself "lucky" that both her consultant and registrar were "very supportive and very proactive in teaching" her. However, by contrast, a later diary entry recorded her anxieties about informing a patient of an imminent operation for which she had little knowledge of the procedures involved:

> 1.40pm. I've just been rung by the Registrar on-call who wants me to see a young lad he's just seen with a query about his testes. He needs to be taken to theatre for further exploration under anaesthetic, so he's asked me to go and see him to consent for this procedure. I'm not really comfortable asking people to consent to procedures that I'm not familiar with. This isn't one I've done before or assisted with before. Ideally, all the guidelines state that the surgeon should always consent the patient before doing it (the operation)...My supervision today was pretty bad actually.
>
> Dr F, Dictaphone Diary.

The quality of training therefore differed between juniors and their various seniors on a substantial scale. Similar experiences were reiterated by other PRHO informants. In spite of these trends evidence collected by the NHS Modernisation Agency found that medical training for junior doctors was far more structured nowadays than in previous times (White *et al.* 2005) when long working hours were the norm:

> A lot of the outcomes on training have actually been improvement in training...better support, decision-making. In some of our pilots there have been support workers to release the juniors for them to attend their training sessions.

Acting Director, NHS Modernisation Agency.

This suggests that reform to medical training had only been a recent initiative, with many believing that it was the result of a broader effort to comply with the EWTD requirements (Marron *et al.* 2005). While this may be so, an argument which states that both medical training and clinical exposure are being adversely affected by the Directive alone disregards the lack of innovation on the parts of doctors and hospital managers to address these matters by alternative measures rather than solely adopting the widespread use of shift systems. Many of the points raised regarding this issue relate to the quality, method and delivery of medical training, over which the EWTD has no bearing. In this light, its impact is minimal. Changes to work patterns and medical training necessitate a corresponding modification in the senior consultants' attitudes. The Dean and Director of the Postgraduate Deanery in Wales, responsible for organising the overall training of junior doctors, was encouraging the use of various teaching techniques in response to the regulated reduction of working time, including informal education such as supervision, mentoring and coaching. Like some other interviewees, he commented on the "uphill struggle" in convincing the older consultants to adapt their educative roles in line with the regulatory changes:

> As most of the educational techniques are foreign to most of the consultants whose one and only method of teaching is lecturing, and whether it's one-to-one, standing around a bed or in a lecture theatre, they behave the same way.
>
> Director and Dean for Postgraduate Dental and Medical Education.

Notwithstanding the consultants' attitudes, the Chief Medical Officer believed that the delivery of medical education was possible under the EWTD regime, provided that the trainee and trainer fully cooperated with the process of change, and used their time effectively. These changes again fall outside of the Directive's ambit. The senior consultants not only needed to adapt in line with the modern regulatory requirements, but also in response to the broader changes facing the NHS.

Many of the discussions focused on the impact of the EWTD on medical training are flawed on the basis that the current state of discontent is largely the product of the methods used to implement the legislation. In contrast to some of the claims made by the study's informants, the Directive plays a limited role on the delivery of medical education. It has been argued that

a collection of these perceptions have been shaped by the influence of senior doctors. Medical training, however, only constitutes one of two integral roles for the juniors. Medical service forms their second function, but both are inextricably linked (Scallan 2003; North West Wales NHS Trust 2002). It is therefore necessary to consider the significance of this second aspect of the junior doctors' purpose to determine the extent of consistency in their views surrounding the EWTD.

Medical staffing and services

Opposition to the EWTD for some informants rested on the notion that restricting junior doctors' working time also corresponded to their more limited presence at the hospital (BMA 2004b), thereby imposing extra pressures on the existing shortages and workload pressures in the health system:

> It's quite hard not to work such long hours, because there's such a large workload, and there are not enough doctors to go around
>
> Dr D.

This view reflects the broader concerns which, in the context of current staffing levels, have prompted concerns that compliance with the European Directive is unsustainable in the UK Health System (Hellawell *et al.* 2005; Molloy 2003; Pickersgill 2001). The reduced presence of juniors in the hospital had therefore provoked within some of these debates the need to recruit more doctors to account for the impact of the EWTD. The discussions in chapter 6, however, have highlighted the continued restricted entry into the profession despite the strain between the demand and supply for medical staffing (Fox 2007). It is argued that this experience is arguably shaped by the profession's historical roots (Larson 1977) and longstanding mode of self-regulation, which have conventionally addressed work issues in a manner suited to the members of the particular sector (Stacey 1992). This theme has consistently underlined the profession's desire to maintain the status quo and to exclude outside influence or intervention, possibly by making its membership less restricted.

According to the Director and Dean for Postgraduate Dental and Medical Education the intakes of PRHOs and Medical students were steadily rising, particularly with the introduction of a new graduate entry scheme into Medicine in Wales. The next four years

were going to see an increase from 240 to 350 qualified doctors here, but the benefits would not be realised in the short term. Furthermore, the Acting Head of the EWTD Pilots at the Department of Health's NHS Modernisation Agency and the Junior Doctor Coordinator at WAG outlined the government's strategy, which was not to recruit more junior doctors but rather to make use of existing resources by ensuring that the presence of junior doctors in hospitals was fully utilised and to redistribute some of their work, hitherto confined to the medical profession, to other members of the healthcare professions.

As the agent responsible for politically and legally implementing the EWTD, the state has had very little input into the process. Typically maintaining its non-interventionist role in workplace relations, since 1997 New Labour has limited its involvement to the funding of a series of pilots which have explored innovative ways at how other workers can perform some of the duties traditionally carried out by doctors (chapter 5). Its power to expand doctor numbers illustrates the continued policy of healthcare rationalisation in areas such as this. The process of addressing the issue has therefore been primarily left to the medical and healthcare professions, and hospital managers.

The debates surrounding work reorganisation also entail far broader discussions about the delivery of medical and healthcare in the NHS than what can be claimed is a result of the EWTD. The redistribution of tasks carried out thus far by junior doctors among the allied healthcare workforce were cautiously welcomed by the informant allied health professions for providing theatre staff, operation department practitioners (ODPs) and nurses with further clinical, managerial and educational opportunities. According to the Royal College of Nursing, the Hospital at Night project (HAN) had promoted the nurses' integration in the out-of-hours' healthcare team, and had elevated their clinical responsibilities such as phlebotomy and ECG monitoring (chapter 5). There were apparent benefits for junior doctors, too. According to both the Dean of Medicine and the Consultant Surgeon, recruiting other non-medically qualified staff such as ward clerks, people in filing and phlebotomists to undertake many of the responsibilities conventionally assumed by the junior doctors consequently released the PRHOs for more clinical work:

> I think there are certain skills or actions that do not have to done by doctors.
>
> Consultant Anaesthetist.

These comments directly link with the discussions on the services carried out by PRHOs alongside their training programmes. Some concerns were, however, voiced about the re-distribution of clinicians' work among existing NHS staff and newly created posts. The ODP described how his workload had recently increased to take account of such changes, and the nurse referred to the increase in her demands but without any corresponding increases in her salary. The feasibility and desirability of fully implementing this strategy therefore posed some difficult questions:

> We are aware that you cannot move the problem to another group of staff. You can't change the role of nursing staff to fill the gap.
>
> Acting Director, NHS Modernisation Agency.

Whereas the concerns among existing healthcare workers centred on issues relating to workload, some of the informants representing the medical profession, depending on their seniority, approached the strategy from a distinctly different perspective. The PRHOs voiced some anxieties about becoming deskilled as a result of their tasks being assigned to other healthcare workers. A number of them spoke about slipping out of practice if some of their duties were not routinely administered by themselves. Senior doctors contributed to this aspect of the debate in a very different way from their junior counterparts. For some of them, passing medical work on to other NHS staff was seen as a form of professional downgrading:

> There is a general downgrading – not in terms of their training but in terms of their ability to undertake service work. Ten years ago, the PRHO used to be the front line; now effectively they are only a student, and this will only increase as the years go by.
>
> Medical staffing manager.

This perceived downgrading was blurring the distinctions between the medical and allied health professions, with the latter assuming more of the work hitherto carried out by junior doctors. Some of the informants embraced these changes, arguing that traditionally demarcation in work roles (Beardwood 1999) had over time frustrated attempts to introduce changes within the NHS:

> The idea that a nurse auxiliary cannot do that particular job because only a nurse can do it, is a whole load of 'toddle'...Why do we put barriers in the way of people? Why do we pigeon-hole people and keep them down?
>
> ODP.

Along with other informants, the Acting Head of the EWTD Pilots at the Modernisation Agency urged the medical profession to reflect on such attitudes, and to approach clinical services by reference to staff competency rather than sustaining assumptions that doctors at a particular grade must carry out a particular task for the sake of convention. In his view, the continuation of such old ideals was antagonising other staff working within the NHS:

> There can be ['us and them culture'], but that can be between medics and surgeons as well.
>
> Dr G.

A physiotherapist interviewee related to this experience, recalling a ward round where it was permissible for a medical consultant to have his mobile phone switched on "but nobody else would dare". Despite this hierarchical approach to workplace organisation and professional identity, the study did identify certain changes in attitude within the medical profession. The RCS promoted the extension of healthcare roles to encompass tasks previously reserved for junior doctors, and the Sub Dean for Medical School Admissions had also observed a "breaking down of barriers between the professions". Inter-professional strategies at Medical School were in place facilitating the process by encouraging undergraduate medical students and their healthcare counterparts to collaborate on certain projects. The benefits of this approach were reflected among several of the PRHO interviewees:

> As a house officer, you work the closest with nursing staff and nurse practitioners.
>
> Dr F, Dictaphone Diary.

Perceptions such as these reinforced the acceptance by many junior members of the profession of the ongoing changes in the organisation of their work. While the discussions underscored some common concerns, the evolving notions of professional identity symbolise

the profession's fragmented outlook to such matters that would once have been approached in a collective manner.

Where does the EWTD fit into this? An officer at the RCN argued that the extension of the nurses' clinical roles was one of the most important repercussions of the EWTD, but at a later point in the interview, referred to this as being a longer trend in which many experienced registered nurses were already conducting tasks that had historically been restricted to doctors. The legislation's remit certainly does not extend to staffing issues. It has therefore served only to highlight the continuing pressures facing various aspects of the workforce involved in healthcare.

For some informants, the EWTD was seen as adversely impacting on medical services. Restricting the working hours of junior doctors translated into less time spent at the hospital treating patients, and a consequent lack of continuity of care. Continuity of care means that the same doctor conducts or oversees all stages of the treatment until the patient is discharged. It was a concept encapsulating a common concern extensively shared among members of the medical profession, but the EWTD's working-time limits were widely seen as negatively affecting the patients' interests:

> [Doctors] are professional people and they are not going to go and leave the patient half sorted out, and leave it for someone else. One thing we drum into them in Medical School is that they have to put the patient above anything else. That permeates the Medical ethos.
>
> Dean of Medicine.

Some doctors' opposition to the legislation on this basis reveals how some informants found it difficult to evenly balance the patients' priority and welfare against their own. For a number of them, the very nature of affording patients the necessary continuity of care necessitated a working environment free from work time restrictions:

> [A lack of] continuity can actually be damaging for patients as well. I would much prefer to be given the option to opt-out of EWTD and do a better job for my patients.
>
> Survey respondent 88.

This view reveals a paradox. Doctors should realise that patients receiving medical services should adapt to the imminent changes to doctors' patterns of work, and accept that continuity of care cannot be provided in ways to which they may have been accustomed in the past. For patients to demand the continuation of this form of service gives rise to an ironic situation that would see them being treated by ill and tired doctors who had spent long hours at the hospital, as a consequence increasing the potential for medical errors. This prospect is therefore equally as damaging for patients (and their doctors). Rather, more emphasis should be on ensuring that better systems are in place with effective 'hand-over' procedures relaying the necessary patient information between doctors commencing and finishing their shifts discussed in the next section.

The study attempted to explore the impact of the regulation on patient services as perceived by some of the informants. Looking at the broader picture, it argues that poorer continuity of care results from the widespread implementation of shift work rather than from the regulation *per se*:

> Doctors [are being turned] from professionals into people that come in to do their job; they clock-in, they clock-out. They will not look after the same groups of patients that they know well to whom they could provide the best services... many PRHOs find their current role is not fulfilling. They are a pair of hands. They don't feel as though they get to know the patients. They get the feeling that their bosses do not know who they are because it's a different person every night.
>
> Consultant Anaesthetist.

Thus arguments over the regulatory impact were again based on perceptions surrounding shift patterns, which were applied in light of the Directive. In doing so, the medical profession and hospital managers collectively failed to consider more innovative and flexible strategies to implement the Regulations which suited the doctors' concerns over the delivery of patient services.

Alternatives

The discussions in chapter 7 showed how the process of implementing the Directive for junior doctors was largely shaped by the widespread application of shift systems. This strategy was the hospital Trusts' attempt to comply with the EWTD's provisions. Some of the claims made by the study's informants in this chapter as to what they regard as the impact of the EWTD are too simplistic. To perceive the Directive as negatively affecting their health, work-life, medical training, staffing, and services overlooks the roles played by both hospital managers and elite members of the medical profession who are charged with implementing EWTD-compliant strategies. The crux of the issue surrounding the EC legislation is not about how the legislation is used as a strategy to reduce work hours and consequently limit clinical exposure, but it concerns the application of a shift-based system of work for junior doctors. Blaming the EC legislature and the regulation itself diverts attention from the lack of innovation on the part of hospital managers and the medical profession to implement more satisfactory measures to meet the time limits prescribed in the Directive:

> Shift working is not conducive to good working practice – you don't move to shift working, and yet here we are with a professional group of workers leading to a working arrangement that is bizarre.
>
> Medical staffing manager.

The EWTD had therefore been a legislative catalyst to the widespread implementation of shift systems (Scallan 2003), yet doctors and managers alike agreed that this pattern of work did not amount to "good working practice", particularly for junior doctors. Paradoxically, the claims made by those in chapter 6 which characterised the Directive as a monolithic legislation whose generic nature was deemed inappropriate for this sector of the labour market are themselves responsible for applying a monolithic, 'one-size-fits-all' strategy, standardising the working time of all medical specialities within which junior doctors undertake their training, by the universal implementation of shift patterns. Applying a generic shift system for juniors has exposed the lack of innovation among hospital managers and senior doctors in putting into place more acceptable measures that correspond to the specific concerns voiced by the profession. This argument therefore calls into question how far such concerns can actually be regarded as an impact of regulation itself, rather than the effects resulting from the response to the legislation.

In light of these findings and drawing upon the literature in chapter 5 (Academy of Medical Royal Colleges 2004; Department of Health 2002b) it is important to consider alternative methods to the implementation of the shift system. The study identified a need for the profession to develop new and innovative methods of delivering medical training and services. The use of technology, for example, should be considered to provide junior doctors with a flexible learning resource that can be accessed at times of the day which complement the demands of hospital and clinical exposure/training (NWP 2006; Department of Health 2003d).

As an alternative to the shift pattern, emphasis should be placed on designing work schedules that incorporate aspects of on-call, subject to a maximum working-time limit and supplemented by adequate compensatory rest. This may resolve some of the concerns voiced by a proportion of the junior doctors who felt that the rigidity of the shift system did not accommodate the opportunities to experience certain unexpected medical procedures.

As regards medical service, a better balance should be struck between the time spent by junior doctors training and working, with more emphasis placed on the former (Academy of Medical Royal Colleges 2004). Such changes should also incorporate an approach to work that immediately addresses the non-clinical tasks which are of no benefit to their training. The study reflected some criticisms voiced in the literature concerning the inappropriate service elements that junior doctors were required to carry out (Department of Health 2002b). The competency required to undertake some of these responsibilities mean that some tasks can be redistributed among existing healthcare staff. In turn, this would ensure that the limited hours of junior doctors spent at the hospital would be more effectively utilised.

Pilot projects should also be designed to develop and test new roles (Academy of Medical Royal Colleges 2004) alongside a review of working patterns for all medical staff (Department of Health 2003d). These recommendations complement the policies put into place to promote greater skills mix and to expand on the number of non-medical practitioner roles in the teams treating patients. In the longer term, and in line with the general increases in medical school places, policies should be put into place to employ more doctors and non-medical staff, including the use of foreign doctors (Fox 2007). This strategy would, to an extent, alleviate the current workload pressures.

Such alternatives should be accompanied by broader changes to the way in which the NHS is delivered. In addition the allocation of further resources, service delivery should be reconfigured so that workloads are firstly transferred appropriately from out-of-hours' periods into normal working days, and that services are diverted geographically to accommodate the decreased presence of junior doctors (Department of Health 2002b). Some of these ideas build on the Hospital at Night initiative and the out-of-hours medical team (see chapter 5).

Conclusion

Having explored junior doctors' perceptions of the impacts of working-time regulation, this chapter shows that despite general support for the EWTD based on its prospects of implementing limited working hours, a better work-life balance, and improved health, there are some anxieties about its effect on medical training, staffing and services. The juniors' concerns surrounded the Directive's adverse impact on clinical exposure and opportunities to attend educational classes in particular, with a smaller proportion referring to capped salaries, poorer quality of patient care and the possibility of becoming deskilled as a result of the redistribution of certain tasks to other workers in the NHS. The EWTD was therefore seen by these informants as constraining the junior doctors' ability to undertake the necessary service and education to meet their professional expectations. This reflects some of the concerns voiced by the senior doctors who criticised the application of a monolithic form of regulation which did not take account of these sector-specific issues. The similarities in some of these views relating to particular aspects of the EWTD reinforced the exclusive culture of the medical profession and its close socialisation processes which facilitate the transmission of ideas on issues such as work conditions, and an occupational resistance to measures such as the Directive.

Shift work is the one chosen solution to implementing the EWTD provisions, but it does not currently work in its present form. Many of the regulatory impacts, however, are not associated with the regulation itself. Nowhere does the Directive prescribe the use of shift work to attain legislative compliance; the methods, assessment and flexibility surrounding medical training are well beyond the legislation's ambit as are medical services routinely performed by junior doctors, staffing issues and the topic of salaries. This study argues that to

claim otherwise represents a narrow view of the Regulations' impact, and fails to take account of the responsibility of the profession for the current state of affairs. The discontent associated with the EWTD, including instances of ill health and poor work-life balance among some doctors, is attributable to the failure of the medical profession to respond to the Directive effectively and in line with the needs of its own members. By allowing managers to address juniors' working time through the implementation of generic and monolithic shift work, the profession has lacked the necessary innovation to apply more appropriate systems that accommodate the specific concerns voiced by its members, and has diluted the potential impact of the EWTD. The organisation of working time through shift work is largely at the root of poor health and fatigue and experiences of ill-balanced work-life, rather than the limited quantity of working hours *per se*. The rigidity of shift patterns do not conform to the flexibility required to deliver patient care in the way it used to be. The discussions have therefore underscored a similar rigidity within the profession with reference to its attitudes, methods and delivery of medical training.

Debates looking at the impact of the Directive in isolation divert attention from the profession's overall reluctance to modify its views in accordance with the broader changes in the NHS. The study did, at times, identify variations in the attitudes of the junior and senior doctor informants, notably in the former's tolerance towards regulation; however, there was no consistent approach to the EWTD. This points to emerging changes in the medical culture, and signals a departure from some ideas which have long permeated the profession's approach to work.

Chapter 9
Conclusion

Introduction

This chapter provides an overview of the study and draws some general conclusions. It is divided into three main sections. It commences with an overview of the findings and draws upon some of the central themes identified in both the previous chapters and the related literature. Secondly, the chapter revisits the research themes and the methods employed to address the study's objectives. It assesses the strengths and limitations of the study and also explores the future applicability of the research. The chapter concludes by exploring the study's contribution towards the broader debates on regulation as part of an overall consideration of the limits of legislation such as the EWTD, and the roles of both the state and the professions in this process.

Revisiting the study

This study explored the various modes of regulation within the UK labour market, with specific reference to the medical profession, to show how historical forms of intervention shaped workers' attitudes towards the organisation of their work today. For senior doctors, their historical modes of regulation through self-governance, professional autonomy and minimal state intervention helped to foster opposition to the EWTD. Ideologically, the Directive represented a centralised form of legal control designed by bureaucrats external to both the profession and the UK. Its failure to conform to an arrangement, such as the New Deal, which was the product of internal and sector-specific discussions, contributed to occupational resistance to the Directive among the higher ranks of the medical profession.

Senior doctors further criticised the application of a monolithic form of regulation that did not take into account the concerns voiced by the medical profession on issues such as medical training, staffing and services. The essence of working-time restrictions limited juniors' presence at the hospital, and consequently their clinical exposure to procedures and attendance at educational classes that benefited their training. It applied pressure to a health system already characterised by staff shortages and excessive workloads, and had prompted policies that redistributed clinical responsibilities and dispersed medical knowledge hitherto confined to the profession, to other members of the workforce. Working-time regulation was

also perceived as adversely affecting the quality of service afforded to patients by fragmenting their continuity of care.

Some of these views had transcended the various medical seniorities, and the study found a proportion of junior doctors raising the criticisms voiced by their senior counterparts, and sharing aspects of their opposition to the law. These informants saw the Directive negatively affecting the junior doctors' ability to undertake the necessary service and education that met their professional expectations. The exclusive culture of the medical profession, its close socialisation processes among members and dissociation with non-members facilitated the transmission of ideas between senior and junior doctors on work conditions, and an occupational resistance to measures such as the Directive.

These views had arisen from the intervention of the European Court of Justice on the Regulations. The study identified a general consensus of support among the elite informants championing the EWTD prior to the ECJ's rulings. Initial support for the legislation derived from the profession's reflections on its previous modes of regulating working time through self-regulation and the New Deal. Underlined by the latter's poor rates of compliance, the junior doctors' excessive working hours were not adequately controlled by either arrangement, and there was no explicit link between the time spent at hospital and the consequent health implications that reinforced the need to promote more stringent forms of control. Furthermore, the lack of punitive sanctions contained in the New Deal underscored the elite informants' support for an alternative mode of regulation. The principle of the EWTD was therefore originally endorsed on the basis that it dealt with the issue of criminal penalties to enforce a statutory maximum working week, while explicitly prioritising the welfare of junior doctors.

The European Court's subsequent interpretation of what constituted working time, however, was widely criticised by both policymakers and medical service providers for incorporating activities hitherto believed to be outside the Regulations' definition. Their disapproval of the ECJ's intervention emerged into a broader critique of general EC law. The preference for a more narrowly construed interpretation of what should comprise working time implicitly renewed support for the New Deal and a working autonomy resembling aspects of self-regulation – models under which the poor protection of junior doctors' hours and health initially led the elites to support the principles of EC law. The position therefore left the elite

stakeholders facing a variety of policy options, none of which were satisfactory owing to the perceived inadequacies in them all. The situation was exacerbated by the weak monitoring and enforcement regimes put into place by the state to implement the Directive's criminal sanctions on those who offended against the provisions. This punitive element was a factor upon which the majority of elite informants in this study based their initial support for the EC law; however, the diluted impact of the Regulations' disciplinary process provided an opportunity for doctors to work long hours and disregard the ECJ rulings without fear of criminal sanctions for hospital managers (or whoever would be liable).

These findings gave rise to a series of paradoxes, the most puzzling of which included participants in a health-based profession not only reporting poor health as a result of working long hours, but also criticising a measure that explicitly prioritised their health by reducing working time. Some of the junior doctors' unwillingness to take time off while ill in order to support their hospital team exposed members of that team to poor health. Furthermore, symptoms of fatigue resulting from their resistance to the EWTD, by continuing to work long hours, were equally damaging the very patients whose well-being was their professional priority.

The PRHOs' reports of their poor health resulting from working long hours represented the medical profession's failure to ensure the best interests of its most junior members. The study also argued that this inadequacy was of a far broader nature, and was encapsulated in the profession's overall response to the EWTD provisions by its implementation of a shift system monolithically spanning the way in which juniors' medical service and training was organised. Paradoxically, the claims made by senior doctors, which characterised the Directive as a legislation whose generic nature was deemed inappropriate for this sector of the labour market, were themselves responsible for permitting managers to implement a 'one-size-fits-all' shift system that standardised the work of all junior doctors. This response to regulation illustrated the failure of the profession and hospital managers to put into place more flexible and acceptable measures that addressed doctors' concerns. The shift arrangements did not take into account the anxieties voiced by juniors about their poor states of health and work-life balance, and the adverse effects on medical training, clinical staffing and health services, in very much the same way as the EWTD, according to the medical elite, did not accommodate the anxieties expressed by the profession as a whole. Alternative methods to the widespread employment of shift systems have included more flexible work

schedules with a degree of on-call, subject to a maximum limit and compensatory rest; e-learning; and changes to the way in which medical services are currently being delivered by the existing staff. Many of these initiatives have already been explored by the Department of Health's Modernisation Agency and NHS NWP.

For reasons that may be related to the recycling of ideals within the closed and elitist medical culture the juniors' apparent discontent with the current state of affairs was directly attributable to the EWTD. This study nonetheless argued that while the EWTD played a certain role in some of their claims, there were a number of factors, such as medical training, staffing and services, which were beyond the Directive's control. It was therefore necessary to look at the roles played by the state, hospital managers and the medical profession to highlight how the juniors' experiences of discontent could be regarded as an impact of the effects resulting from the response to the legislation, rather than from the regulation itself.

The general inconsistency in the informants' responses demonstrates some resistance to change within the profession and reflects the some of the mixed attitudes towards EC regulation adopted by the elite informants in chapter 6. While the prospect of better work hours, health and work-life balance influenced a pro-regulatory school of thought among many of the juniors, they perceived the EWTD as adversely affecting other facets of their work. The partial fragmentation of the medical community's outlook on external regulation, evidenced by the PRHOs' general acceptance to work shorter hours in compliance with the EWTD, illustrated the evolving nature of the medical profession.

The approach

This study has been guided by an overall aim to analyse the process and impact of legal regulation on working conditions in UK labour markets, with specific reference to the EWTD and its impact on the junior medical profession. A series of objectives emerging from this general concern have been addressed in both the study's empirical research and findings; they attempted to:

1. analyse the views of elite stakeholders about the political and legal debates surrounding the regulation of working time;

2. examine critically the ways in which the EWTD has been implemented and enforced in practice in relation to junior doctors, and the sources of support and resistance to such processes; and,

3. analyse the apparent impact of regulating working time on the work and lives of junior doctors.

These objectives were addressed using a mix of research methods, including semi-structured interviews with policymakers, medical service providers and the members of the judiciary; two postal questionnaires sent to every PRHO in Wales, and a pair of Dictaphone diaries. In line with the methodological limitations, however, the findings must be interpreted cautiously. The self-reporting nature of the survey poses questions about the reliability of the data gathered, particularly as there is no comparative research against which the responses can be verified. Therefore gauging the impact of the Regulations using the questionnaire data can be something of a speculative exercise, given that there are few sources of information comparing the situation before and after the EWTD's implementation. Attempts to restrict the sampling, geographical and contextual boundaries similarly limit the extrapolation of the study's findings. By defining the issues in terms of labour-market regulation without considering the topical emphasis on regulatory governance of a clinical nature in and including the ongoing broader reforms in the NHS, the study's straightforward assessment of working-time restrictions on the lives and work of junior doctors is limited. In the same respect, the survey respondents have been drawn from one of seventeen Deaneries across the UK, restricting the ability to generalise the findings.

The study may have identified different findings had it focused on a single hospital or Trust, and had included the use of ethnographic techniques. A greater emphasis on this kind of qualitative research could have given rise to a more in-depth understanding of the relationships underpinning the social milieu in which the participants inhabited. The findings therefore lack the potential rigour of a single-site study. However, the general limitations of ethnographic methodology and its focus on understanding the social environment made this unsuitable for addressing the research objectives of this study. Nor did the desire to explore beyond the parameters of a single setting, and to gauge the attitudes of many stakeholders between such extreme micro and macro levels, easily sit alongside the principles associated with these qualitative methods.

It was felt that a study focusing on a sample based at one location would not reflect doctors' variation in experiences nor would it have starkly highlighted such themes as the inconsistent implementation, enforcement and compliance with the Directive's provisions, not only between different Trusts and specialities but also between EC Member States. Focusing beyond parameters limited to a single location, the study was able to draw out the degree of inconsistency in views held by both senior and junior members of the medical profession and to elicit the necessary data to correspond with the research themes.

The study has also benefited from drawing rich data from a broad variety of sources including a number of elite stakeholders whose perspectives at devolved, national and European levels are represented. The process has been facilitated by unique access to a set of informants through using personal networks. The importance of the overall study is underlined by the tendency in previous research to concentrate on some individual aspects and themes of working-time regulation, such as health, work-life, medical training and NHS services, within both labour-market and medical-specific contexts. The primary contribution made by this study therefore rests in its attempt to address the present lacuna in research by encapsulating all of these interrelated issues within a specific and contemporary context focusing on a topical European regulation.

Its general importance is also underscored by its comparative value to potential future research on working-time regulation. It sets the scene for studies of a similar nature exploring issues of implementation and compliance with the EWTD's stricter limits on doctors' working time by 2009, or for research aiming to analyse comparable objectives among different seniorities within the medical profession, or within different geographical areas. The findings from this study could also be used to evaluate the similarities and differences between the issues facing the medical profession under the EWTD and other sectors in the labour market, whether they, too, have a history of self-regulation, such as the legal profession, or not.

Regulation: Prospects

The study's focus on various modes of regulation, and their impact on the labour market, reflect some of the broader debates contained in the literature which focus on the role of

regulation, its limits, and the significance of both the state and those whom are subject to the regulation (Gunningham and Grabosky 1998; Hutter 1997; Hawkins 1984). The regulation of public services entails "processes by which standards are set, monitored and/or enforced in some way, by bureaucratic actors who are somewhat separate from units or bodies that have direct operational or service delivery responsibilities" (Hood and Scott 1996: 321). Its rationale stems from a number of factors, which includes the interest of the public at large (Baldwin *et al.* 1998); governments must be seen to be intervening for such legitimate purposes (Haines and Gurney 2003). Regulation therefore poses a delicate balance between the interests of industry and the public. On the one hand, this study has shown the financial reasons underpinning the bureaucratic intervention in the public sector that was initiated by the Conservative Party elected in 1979, and its continuance in addition to new forms of state regulation carried out by New Labour through clinical governance and GMC reform, to ensure the quality of care provided to the public at large (Davies 2000). On the other hand, an occupational health and safety measure such as the EWTD specifically illustrates the government's reliance on law to achieve goals of a social nature, namely to create safer workplaces (Ayres and Braithwaite 1992; Haines and Gurbey 2003).

Legal regulation is therefore seen as being able to incorporate (albeit not equally) the varying concerns of different stakeholders. The relatively recent increase in the use of law reinforces Britain as a regulatory state (Majone 1996). Its management which leaves less scope for local variation contrasts with the historical tradition of laissez-faire in the UK. Minimal state intervention has been a longstanding feature in the UK's labour market, and is stimulated by concerns voiced by both industry and governments which prioritise the benefits of market competition within the economy (McIvor 1987; Hart 1987).

Centralised statutory regulation of employment relations in the UK has therefore been rare, with only the conditions of specific industry sectors and particular workers having been the subject of regulatory control (Bishop and Mayer 1995; Dawson *et al.* 1988). Issues such as pay, working time and processes surrounding the termination of employment were chiefly negotiated between trade unions and employers alike on a voluntarist standing (Cully *et al.* 1999; Dawson *et al.* 1988). Thus general labour conditions and relations in the UK have been consistently set against the interrelated themes of economic competitiveness and regulation-free markets. These fundamental characteristics, and the respective bargaining strengths of employers and unions, have long associated the former with an overbearing authority on

matters regarding workers' conditions of employment (McIvor 1987). Employers' influence was also reinforced by policies of non-intervention shared by both the state and the judiciary.

These trends have been perceived by some as resulting in poorer protections for the worker (Napier 1991). Examples in this study have illustrated the employers' continuing influence over their workers' conditions of employment to the latter's detriment by insisting that they opt out of the EWTD's protections (Barnard *et al.* 2003). However, the general absence of historical regulation and predominant role of trade unionism in the UK have not always necessarily disadvantaged the workers compared to those in Europe whose labour conditions have, by contrast, been more strictly regulated by civil codes. For example, reports in the 1830s and 1870s revealed that the average weekly hours of work in an English cotton mill was 69, compared with 72-84 and 72-90 in France and Switzerland, and in Prussia, respectively (Hunt 1981). Britain's trade union campaigns which focused on attaining a 40-hour week in the 1960s resulted in the British workplace being "the more extensively regulated by the middle of the twentieth century than any other developed nation" (McIvor 2001: 170-71). Such working hours in Europe did not follow suit until the 1970s (Palmer and Evans 1985).

Relatively unregulated markets in the UK, supplemented by a tradition of active trade unionism, has seen some workers in Britain at particular times in history experiencing comparably better labour conditions in spite of recent reports which indicate that they now work among the longest hours in Europe (Eurofound 2007). This latter trend, which continues almost a decade after the implementation of the EWTD, reflects the limits of regulation. Extra-legal factors that affect the implementation of laws include the ambiguous nature of legislation, problems of enforcement, and the active resistance of powerful groups (Anleu 2001). The success of regulation is therefore often mixed, suggesting that it does not consistently achieve its stated or apparent objectives (Dingwall 1989).

Compliance with regulation can be shaped by the nature of the legislation. Some perceive the operation of law as a way of resolving uncertainties that arise in specific factual situations (Geertz 1983). However laws can, by their tendencies to specify broad and ambiguous principles, give organisations a wide scope of discretion to determine the meaning of compliance (Edelman 1992). Legislation regulating the employment relationship is a prime example of the state's use of broad and indefinite standards (Hutter 1997). This ambiguity

can often lead to more detailed and specific legislation, thereby increasing the quantity of regulation on the one hand, but also providing more opportunities for contest on the other. By attempting to resolve ambiguities, law is used as a recurrent mechanism to reconstitute the boundaries of those subject to regulation. Law creation or reform is therefore a "dialectical process, whereby conflicts and dilemmas are resolved, yet their resolution creates further tensions and disagreements that are often managed by creating more laws, increasingly specifying legal provisions and definitions" (Anleu 2001: 436).

This study showed how a European law whose broad and ambiguous principles led to a confusion of legislative intentions among the state, judiciary, and the subjects of the regulation. Subsequent revisions complicated the legislation's implementation and resulted in widespread non-compliance among the majority of Member States. Two points arise from this finding. First, little has been done to address the character of such regulation. The European Community continues to pass Directives which are, by nature, typically broad in order to allow individual governments to harmonise their national provisions with the supranational legislative framework (Snyder 1993). In the UK, New Labour similarly persists to transpose such regulation in minimalist form (Smith and Morton 2006; Deakin and Wilkinson 2005), thereby sustaining the foundation upon which organisations can interpret the ambiguities that accord with their intentions, provide opportunities for further contest, revisions and reform, and shape overall regulatory compliance (Yaegar 1991).

Secondly, the confusion resulting from what the medical profession had anticipated was the definition of working time, in contrast to the ECJ's actual interpretation, is arguably the result of the state's broader approach to such social regulation. By ambiguously framing the fundamental terms of the EWTD, the legislature shaped this particular law with reference to the state's longstanding concern to ensure that the UK labour market operates with as few restrictions as possible, and that the essence of competition is not constrained by regulation. The broad nature of the Directive provides the space to limit its practical impact and to reduce the constraints and difficulties it might cause for particular sectors in the labour market. Yaegar (1991) argues that law is sensitive to the tensions and instabilities inherent in political economy. In part to avoid political damage to itself, he also argues that the legislature tends to pass regulatory legislation only in outline, leaving the potentially riskier implementation decisions, from which higher levels of conflict are likely to emerge, to its

agencies. In this instance, the opposition among doctors relating to the EWTD was diverted from the state, towards hospital managers and the ECJ primarily.

Elements supporting the state's deliberate attempt to undermine the efficacy of legal regulation arguably apply to the UK, particularly in relation to the policing mechanisms put into place to ensure the legislative provisions are observed. Enforcement is defined as the "consistent application of formal rules, indicating sanctions, to secure compliance with the enabling legislation (Snider 1991: 213). Regulatory laws, however, often have weak enforcement provisions, and regulators have insufficient resources to police compliance. Furthermore, there is little incentive to observe the regulations if their modes of punishment do not fall within the ambit of the criminal process (Glasbeek and Roland 1979; Glasbeek 1984; Pearce and Tombs, 1990a and 1990b). By their nature, regulations are generally not the subject of criminal sanctions; the term 'regulation' implies a degree of tolerance of the activities under scrutiny rather than their elimination. Thus the aim is to regulate or to control, not to repress (Hawkins 1984), and to gauge a form of compliance through long-term cooperation and informal enforcement techniques including education, advice, persuasion and negotiation (Hutter 1993; Gunningham and Grabosky 1998). This was largely the position under the provisions contained within the doctors' New Deal. Before that regulation, working time was a matter restricted to individual doctors (and the BMA) and their employers, as was the case for the general workforce resulting from the absence of national legislation.

The study found that poor compliance with the New Deal requirements was arguably shaped, to an extent, by the lack of credible sanctions facing employers that failed to observe the regulation. By contrast, the EWTD could potentially imprison chief executives. It was claimed by some of the study's informants that this feature of the legislation was one of the primary factors underlying employers' attempts to drive down the working hours of junior doctors and consequently improved their health. Their views were, however, undermined by a number of factors. Many junior doctors continued to work over and above the working-time limits prescribed by both the legislation and their employment contracts, and instances of poor health continued to be reported despite the legislation in force. Furthermore, the UK's general enforcement and monitoring regimes diluted the potential impact of the regulatory sanctions. The contrast between the potential seriousness of the sanctions, and the actual practical possibilities of applying them in the absence of proper audited central records of

work hours, raises questions about the regulations' enforceability (Yaegar 1991). A significant source of law's weakness and non-compliance results from the absence of effective monitoring mechanisms (Allott 1980).

The ambivalent approach to record-keeping also suggests that the authorities were, to a degree, turning a 'blind eye' to the possibility of non-compliance with the provisions contained within the EWTD. This was further supported by the state's attempt to dilute the regulatory impact by ambiguously framing the fundamental terms of the regulation (Edelman 1992), a claim implicitly referred to by two senior members of the UK and European judiciary. These arguments are, however, speculative. Further substantial evidence is required from detailed interviews with key stakeholders not included in this study, that is, the politicians and specific bureaucrats who actually took the decisions and framed the legislation. It is informed speculation nevertheless, supported by some data arising from the interviews with the two ECJ judges and in the overall assessment of the contradictions and complexities arising from the EWTD, and its implementation in the medical sector.

The state's consistent minimal intervention – encapsulated in this context by inadequate auditing controls, a consequent weak enforcement regime, and a process of implementing an ambiguously defined regulation which is shaped by the absence of clear and consistent national guidance – supports the argument that the EWTD serves more as a symbolic function rather than an instrument to effect substantive change. A number of the study's informants perceived the recent reduction in junior doctors' working time as a direct result of the Directive. These trends were claimed to have arisen largely in consequence to hospital managers' fears about the Regulations' criminal sanctions. However, this line of argument is, to an extent, flawed by the EWTD's weak enforceability. Widespread non-compliance among the majority of Member States has made the European Commission's possibility of initiating proceedings against individual hospital chief executives unrealistic. The lack of centralised evidence in both the UK and EC of compliance with the EWTD upon which prosecutions can be brought represents a drain on the Commission's limited enforcement capacity. Overall, this undermines the fundamental principles of a European Community based on law, and is an obstacle to the credibility and legitimacy of supranational regulation (Snyder 1993).

It is reasonable to argue, therefore, that the primary impact of the EWTD (at least to date) derives from the symbolic element of the law, given that the actual prospect of prosecution is

unlikely. Those who viewed the Directive as the primary vehicle in driving down junior doctors' hours may or may not have been aware of the existing data which shows that working hours were already in decline following initiatives such as the New Deal. In this sense, the EWTD has continued an already present trend, rather than signalling a dramatic new direction. In similar respects, some of the junior doctors in this study perceived the EWTD as providing an element of safety to their personal health against a backdrop of what they saw was a long hours' culture in the medical profession which adversely impacted their welfare. In reality, however, information gathered from the interviews and surveys revealed that a significant proportion continued to experience some form of illness, despite the legislation's enforcement. It is highly questionable whether a law alone can improve doctors' health and safety, more so in a typically stressful working environment such as the NHS. The law therefore has both an expressive function – sending out a strong message about what is acceptable and what is not acceptable – and an instrumental one – to actively impose controls on particular kinds of behaviour (Yaegar 1991; Kuhn 1961). It has also served to invigorate key debates (and tensions) on issues such as healthcare roles, patient services and medical training (North West Wales NHS 2002), which long existed before the implementation of the legislation.

The general problems of enforcement can also be shaped by the way in which regulators can be co-opted by the industry they are supposed to regulate (Gunningham and Grabosky 1998; Gunningham and Rees 1997; Grabosky and Braithwaite 1986). The lack of cooperation among those being regulated can adversely affect the legislation's overall compliance (Makkai and Braithwaite 1993; Kagan and Scholz 1984). Law must therefore interact with other regulatory mechanisms (Hunt 1993). This can sometimes result in tensions between legal and other norms, which consequently compromise the impact of legal regulation (Allott 1980). These issues relate to the broader extra-legal factor that can inhibit the implementation of laws, namely the active resistance of powerful groups.

Given that the behaviour of those subject to the regulation may be influenced in some way, socio-legal debates look to the significance of cultural and organisational dimensions, and their role within the regulatory process (Dingwall 1989). Legislation of a general nature may clearly conflict with the normative orders of self-regulating professional communities (Huyse and Parmentier 1990), and among those historically accustomed to a degree of autonomy as part of their professional work (Freidson 1994). This study argued that the historical modes

of regulation through self-governance, professional autonomy and minimal state intervention helped to foster opposition to the current EC law among many senior doctors:

> Legislation and administrative guidelines conflict with professional autonomy by regulating areas of work expertise that professional actors consider within their exclusive jurisdiction. They thereby seek to defend their professional project from what they see as inappropriate legal/government encroachment.
>
> Anleu 2001: 420.

An occupation's ability to attain professional status is shaped by achieving autonomy and immunity from external forces (Freidson 1994). These self-regulatory controls can be underpinned by concerns towards alternative modes of governance, which are external and bureaucratic by nature (Gunningham and Grabosky 1998; Gunningham and Rees 1997). Self-regulation models therefore aim to facilitate the harmonisation of competing interests held by both the state and professional groups rather than dichotomising demands and forcing choices (Haines and Gurney 2003). In addition to its voluntarist approach to the labour market, the state's lack of medical expertise has meant that it has conventionally left the administration and policymaking of medical care to doctors. In turn, the medical profession has self-regulated both its activities and the delivery of care, securing its elite status in the labour market (Freidson 1970a, 1970b). Centralised regulation does not, however, conform to sector-specific concerns in the same way as it does not account for local circumstances (Davies 2000). Furthermore, McGuire (1989) argues that the individualistic nature of the treatment process makes both the choice and the efficacy of treatments open to variation; the limits of regulation are also therefore characterised by the nature of the work carried out by doctors.

The state, however, retains the authority to allow sectors of the labour market to self-regulate (Moran and Wood 1993; Miettinen and Flegel 2003; Hilton and Slotnick 2005), and it did so for the medical profession by passing the 1858 Medical Act. As a result, the state in this sense remains the ultimate sovereign and if it historically decided to afford the profession with autonomy, then it can also retract it (Cruess and Cruess 1997; Hutter 1997):

> Self-regulation will be developed in the shadow of the law where the broad policy parameters have already been established by government, and industry is merely given discretion over the means by which these overriding objectives are achieved.
>
> Sinclair 1997a: 544.

While the rise in regulatory bodies will correspond to a continuing increase in guidelines, policies and best practice (Davies 2004), which pose an ongoing challenge to the medical profession (Klein 1998), such regulations – particularly of a clinical nature – will necessitate the expertise of doctors (Kendall *et al.* 1996; Flynn 1999). Both managers and its agents remain dependent upon the profession for its knowledge (Davies 2000; Kirkpatrick *et al.* 2005) and the public perception of legitimacy associated with doctors which managers typically lack (Pollitt 1993; Learmonth 1997). Thorne (2002) argues that NHS managers are weakened by having no specific claims to the expertise that relate to the Health Service. They are invisible to patients, have no claim to professional independence and are agents of government, employed to implement, rather than question, political decisions.

The result is a "regulative bargain" (Kirkpatrick *et al.* 2005; Irvine 2006) and a balance of power shared between the profession and the state, with the latter granting the former an "organised autonomy" (Freidson 1970b) or a form of "responsible autonomy" (Dent and Burtney 1996) rather than a distinct independence (Coburn *et al.* 1997). As such, there is evidence of different modes of external and internal regulation simultaneously operating in the way the profession's work is organised.

The question that thus remains is what the future holds for regulating the profession. Bureaucratic intervention and the centrality of hospital management initiated by the Conservatives continue under New Labour (Berg 1997), and the core themes of new public management in the NHS look likely to remain for the foreseeable future (Hannigan 1998). Managers are now entrusted with greater controls than ever over the terms and conditions of doctors' work (Harrison and Ahmad 2000; Harrison 1999a; Kelleher *et al.* 1994). The ideologies between both governments are reflected in the current climate with renewed emphasis on regulating the medical profession through forms of both clinical governance and reform to its disciplinary procedures, all of which leaves the future status of the health care professionals in a state of uncertainty (Beardwood 1999).

The emphasis on clinical governance, stemming from concerns surrounding the quality of medical care, illustrates the state's continued attempt to regulate the professions (Davies 2000), and to scrutinise the work of doctors through a proliferation of clinical regulatory bodies. On 21 February 2007, the government published its white paper *Trust, assurance and safety – the regulation of health professionals in the 21st century* (Department of Health 2007), which sets a framework to assure the safety of patients and quality of care. The paper considers the English Chief Medical Officer Sir Liam Donaldson's review of medical regulation, *Good Doctors, Safer Patients* (2006a) to cover areas such as the introduction of an effective system of revalidation, to alter the standard of proof in case of doctors' fitness to practise, and to implement modifications to the role, composition and function of the GMC. The BMA opposed the proposals, arguing that they further encroach on the work of doctors and directly impinge on the self-regulatory nature of the profession (Kmietowicz 2007).

The state's regulation is not, however, confined to the medical profession alone. The Legal Services Bill will soon introduce the so-called 'Tesco law', permitting companies, rather than solicitors' or barristers' chambers alone, to own law firms and provide legal services for the first time. The Bill will also set up an independent Office for Legal Complaints, and create the Legal Services Board to oversee the regulation of the legal profession. Lawyers, like doctors, have opposed what they perceive as an extension of state bureaucracy over their profession (Plattern 2004).

Recent domestic trends therefore underscore a consistency in state intervention within the UK labour market. Some of these aspects derive from the continent; however there is little evidence to suggest that the process will be reversed in the foreseeable future. The professions are also diversifying at extraordinary levels (Williams 2001), making the transmission of common values more difficult (Cruess and Cruess, 1997). The most significant evidence supporting this claim is the apparent departure from traditional attitudes among some junior doctors and the younger consultants in the NHS, and a growing acceptance of the external regulation of their work.

There is no real resolution regarding the most appropriate model for managing the working time of junior doctors. This study has identified a distinction between self-regulation and state intervention which is at its best blurred by the simultaneous operation of both forms of control on the medical profession. The implications in practice have raised questions about

the role of the state as a public body charged with the responsibility of ensuring the necessary resources to deliver a system of care under the EWTD regime. The debates surrounding the regulation – the doctors' health and work-life, their medical training, and medical staffing and services feature very little in the state policies. The responsibility therefore rests with the medical profession to accommodate the Directive within the given parameters. In practice, this has been implemented through the widespread application of the shift system. Despite the general absence of state intervention, this study has nonetheless showed how the profession has relied upon the former's deliberate attempts to 'fudge' regulation. This apparent preference for vague legislative standards is perhaps consistent with the broader history of UK workplace relations where self-regulation and corporatist bargaining have been viewed as preferable to direct statutory controls. In the light of the findings of this study, it seems reasonable to conclude that the EWTD in its current form seems unlikely to provide the cure for long working hours in the medical profession and all the associated problems.

Appendices

POSTAL QUESTIONNAIRE: WORKING HOURS AND JUNIOR DOCTORS

Thank you for participating in this survey. The questionnaire should take about 5 minutes of your time to complete. Your replies will be treated in strictest confidence, and no individual will be identified in the thesis. Please circle the appropriate answer, or write a short reply where requested.

1. ABOUT YOURSELF

Are you MALE FEMALE (Please CIRCLE)

How old are you?.....(years)

Please specify what type of hospital you are currently working in:

TEACHING NON-TEACHING (Please CIRCLE)

2. GENERAL – WORKING HOURS

2.1 Currently, how many hours do you work on average per week?
(please include on-call periods when you are required to be physically present at the health centre).....

2.2 Do you work overtime? YES / NO (Please CIRCLE)

2.2 If YES, on average how many hours a week of overtime do you work?

.....

3. EFFECTS OF WORKING HOURS: PERSONAL HEALTH & WORK-LIFE BALANCE

3.1 Please indicate if you currently suffer, or have suffered during your training period,

any of the following symptoms that you would attribute to the hours you work (Please TICK all that apply)

Depression	Emotional distress
Weight Loss	Insomnia
Stress	Anxiety
Exhaustion and/or Fatigue	Tension
Mood symptom	Headaches and/or migraine
Suicide thoughts	

3.2 How willing are you to take time off work for reasons related to personal health?

(Please CIRCLE one of the following)

Very Willing Willing Don't know Unwilling Very Unwilling

3.3 How satisfied are you with your work-life balance?
(Please CIRCLE one of the following)

Very Satisfied Satisfied Undecided Unsatisfied Very Unsatisfied

3.4 Do you think that the NHS offers sufficient flexible working hours options?

YES / NO (Please CIRCLE)

4. EFFECTS OF WORKING HOURS: TRAINING & SERVICE

4.1 Do you feel that you have sufficient time to attend educational meetings and/or periods of educational study?

YES / NO (Please CIRCLE)

4.2 Would you be satisfied with a reduction in your working hours if this meant a decrease in your study leave allowance?

YES / NO (Please CIRCLE)

4.3 Is it possible, in your opinion, to reduce working hours and maintain your current study leave allowance?

YES / NO (Please CIRCLE)

4.4 Please respond to the following statement: "Long working hours for junior doctors significantly raises the risk of medical errors"

Strongly Agree Agree Undecided Disagree Strongly Disagree

5. REGULATING DOCTORS' WORKING HOURS

5.1 Are you aware that the Working Time Directive states that from August 1st 2004 junior doctors should not work more than 56 hours per week?

YES / NO (Please CIRCLE)

5.2 Should doctors in training be exempt from legislation curtailing their working hours?

YES / NO (Please CIRCLE)

If yes, please briefly state reasons

.....
.....

5.3 If the terms and conditions of your service exceeded the number of working hours stipulated in the legislation, would you take any action?

YES/NO (Please CIRCLE)

If YES, please give brief details of the action you would take (eg. inform Trust, legal action etc)

.....
.....
.....

5.5 Would you work longer working hours if your salary and/or overtime payments were substantially increased?

YES / NO (Please CIRCLE)

5.6 Given the option, would you waiver your legal entitlement to work a 48-hour week?

YES / NO (Please CIRCLE)

If yes, please briefly state reasons

.....
.....

If you would like to be paid to give a short informal interview on the subject of working hours, or offer any other views on this research, please provide contact details below:

NAME .....

ADDRESS .....

.....

.....

CONTACT PHONE NUMBER.....

THANK YOU VERY MUCH FOR YOUR TIME

DICTAPHONE DIARY

You may use this as a guide of themes to cover before, during and after your working day. Please answer or respond to as many of the themes outlined below and, if it is possible during work, keep an eye out on whether anybody else (consultants, senior training grades, patients, management, other PRHOs and NHS staff) refers to them.

Your Working Day

In a few words, describe your day today.

Has this day differed to your average working day – if so: how and why?

Who have you socialised with today – before, during and after work?

Did anything make you angry, annoyed, frustrated, emotional, laugh, etc. today? What & why?

Did/do you have any regrets about going in to work today & why (not)?

What were the high and low points?

Hours of work

How may hours have you worked today?

Did you work below or over your hours? Why?

Did you stay/were you expected to stay?

Did you take any breaks? If so – how long/many; if not – why?

Did you have the opportunity, and did you eat / socialise / refresh?

Work Relations

Who did you work with today (consultants, senior training grades, patients, management, other PRHOs and NHS staff, etc.)?

Are these any different to your average working day – how/why?

Please recall what you did and spoke about (work and non-work) with these various people, even during break times.

Was there any conflict between these people? If so, what was the issue?

Medical Training

What 'training' activities did you undertake today?

Were any of these new to you? If so, how well were they taught, and how confident are you to practise them with/without supervision?

If you did not learn anything 'new', how do you feel about this (e.g. frustrated)?

How was your supervision today? Were you satisfied with the teaching methods?

Medical Service

Was there more of training or service today? How do you feel about that?

Describe your service work today, e.g. patients and treatment, and your workload

Did you receive any complaints (general or personal)? If so, what was your response?

Did you work on-call? If so, for how long? What did you do? Was this of value to your training and/or service? Did you feel poorly or tired during or after this period?

Do you feel that you are missing out on experiences, e.g. by not doing on-call work?

How much patient contact did you have? Are you satisfied with this? Did you give the same proportion of quality care throughout the whole of your day?

Did you or somebody else commit any errors? What was the reason, if so?

List your separate training and service activities, and in terms how their personal benefit to you?

Were any of your experiences today 'inadequate' or your tasks inappropriate?

Was any of your time wasted? How and why?

From the minute you left the house this morning, what would you define as working time, for you personally?

Health

Did you feel poorly at all today (including fatigue and tiredness)? If so, what was the significance of working time and non-work?

Were any of your colleagues poorly, for the same reasons?

What was the working environment like?

Did/Could you have considered residing at the hospital? Please give reasons explaining what you did.

Did you prescribe medication to other doctors, or hear about self-prescription among your colleagues?

Work-life

What did you do after work? Did you have plans that you didn't fulfil?

Have you got plans scheduled for the rest of week and if so, do you think you will be able to fulfil them after today?

How much time have you spent with other people/your partner after work (please say briefly who these people are)?

Has your working time become an issue in relation to these people?

General Questions

Given patient and staff numbers, traditionally a long hours job following a long undergraduate course, the effects on health and work-life balance, what did you do today that made you think that this job is worthwhile?

Was working time mentioned by anybody else today in conversation?

Did anything occur today that you or your colleagues noticed that would lead you to report it to your consultant / management or trust / BMA? What, if so, and what was your response (& why)?

Do you think the Working Time Directive would impact on your work /training /personal life, after today? If so, how and would you welcome an impact?

How satisfying was your job today, considering all of the above pointers?

Bibliography

Academy of Medical Royal Colleges (2004) 'Implementing the European Working Time Directive: A Position Paper from the Academy of Medical Royal Colleges.'

Adnett, N. and Hardy, S. (2001) 'Reviewing the Working Time Directive: rationale, implementation and case law'. *Industrial Law Journal*, 32(2): 114-125.

Ahmed-Little, Y. (2007) 'Implication of shift work for junior doctors'. *BMJ*, 334: 777-778.

Aitken, M. and Paice, E. (2003) 'Trainee's attitudes to shift work depend on grade and specialty'. *BMJ*, 326: 48.

Alkhulaifi, A., Allen, S.M., Anderson, J.R. (1995) 'New Deal not satisfactory for cardiothoracic surgery'. *BMJ*, 311: 953.

Allen, I. (2005) 'Women doctors and their careers: what now?' *BMJ*, 331: 569-572.

Allen, I., Brown, P., Hughes, P. (1997) *Choosing Tomorrow's Doctors*. London, Policy Studies Institute.

Allen, I. (1994) *Doctors and their Careers A New Generation*. London, Policy Studies Institute.

Allott, A. (1980) *The Limits of Law*. London, Butterworths.

Amicus (2003) *Working Time Regulations, Amicus guide for members*. London, Amicus.

Anleu, S.L.R. (2001) 'The Legal Regulation of Medical Science'. *Law and Policy*, 23, (4): 417-441.

Audit Commission (1995) *The Doctors Tale: The Work of Hospital Doctors in England and Wales*. London, HMSO.

Arrowsmith, J. (2002) 'The Struggle over Working Time in Nineteenth- and Twentieth-Century Britain. *Historical Studies in Industrial Relations*, 13: 89-117.

Arrowsmith, J. (2001) 'Government calls for better work-life balance'. *European Industrial Relations Observatory On-line*, <<http://www.eiro.eurofound.ie/2001/02/feature/UK0102115F.html>> (Accessed 03/12/03).

Arrowsmith, J. (2001b) 'Research highlights limited impact of Working Time Regulations'. *European Industrial Relations Observatory On-line*, <<http://www.eiro.eurofound.ie/about/2001/05/feature/UK010513F.html>> (Accessed 03/12/03).

Ashworth, R., Boyne, G.A., Walker, R.M. (2002) 'Regulatory Problems in the Public Sector: Theories and Cases'. *Policy and Politics*, 30(2): 195-211.

Atkinson, P. (1995) *Medical Talk and Medical Work: the Liturgy of the Clinic.* London, Sage.
Avery, V. (2004) 'Measuring working time arrangements'. *Labour market trends*, Jan: 15-17.

Ayres, I. and Braithwaite, J. (1992) *Responsive Regulation: Transcending the deregulation debate.* New York, Oxford University Press.

Bach, S. (2004) *Employment relations and the Health Service.* London, Routledge.

Bach, S. (2002) 'Muddling through on modernisation: public service employment relations in the NHS'. *British Journal of Industrial Relations*, 40 (2): 319-39.

Bailey, R. (1994) 'Annual Review Article 1993: British public sector industrial relations'. *British Journal of Industrial Relations*, 32: 113-36.

Baldwin, P.J., Dodd, M., Wrate, W. (1997a) 'Young doctors' health – I. How do working conditions affect attitudes, health and performance?' *Social Science Medicine*, 45: 35-40.

Baldwin, P.J., Dodd, M., Wrate, W. (1997b) – II. Health and health behaviour'. *Social Science Medicine*, 45: 41-44.

Baldwin, P.J., Newton, R.W., Buckley, G., Roberts, M.A., Dodd, M. (1997c) 'Senior House officers in medicine: postal survey of training and work experience'. *BMJ*, 314: 740-743.

Baldwin, R., Scott, C. and Hood, C. (eds.) (1998) *A Reader on Regulation.* Oxford, Oxford University Press.

Ball, S. (1994) 'Political Interviews and the Politics of Interviewing'. In Walford, G. (ed.) *Researching the Powerful in Education.* London, University College London Press.

Barnard, C., Deakin, S., Hobbs, R. (2003) 'Opting out of the 48-hour week: Employer Necessity or Individual choice? An empirical study of the operation of article 18(1)(b) of the Working Time Directive in the UK'. *Industrial Law Journal*, 32(4): 223-252.

Barton, J. and Folkard, S. (1993) 'Advancing versus delaying shift systems'. *Ergonomics*, 36(1-3): 59-64.

Barton, J., Spelten, E., Totterdell, P., Smith, L., Folkard, S. (1995) 'Is there an optimum number of night shifts? Relationship between sleep, health and well-being'. *Work & Stress*, 9: 109-123.

Bates, E. (1982) 'Doctors and their spouses speak: stress in medical practice'. *Sociology of Health and Illness*, 4(1): 25-40.

BBC News (2006) PM urges progress on UK pay gap <<http://news.bbc.co.uk/1/hi/business/4753360.stm>> (Accessed 26/03/06).

Beardwood, B. (1999) 'The Loosening of Professional Boundaries and Restructuring: The Implications for Nursing and Medicine in Ontario, Canada'. *Law and Policy*, 21 (3): 315-343.

Bearley, S. (1991) 'Medical Manpower'. *BMJ*, 303: 1534-1536.

Becker, H.S., Geer, B., Hughes, E.C., Strauss, A.L. (1961) *Boys in White*. Chicago, University of Chicago Press.

Beecham, L. (1999) 'Medicopolitical digest'. *BMJ*, 319: 858,

Bell, D. and Hart, R. (1998) 'Working Time in Great Britain, 1975-1994: evidence from the New Earnings Survey panel data'. *Journal of the Royal Statistical Society*, 161 (3): 327-348.

Berg, M. (1997) *Rationalizing Medical Work: Decision-support techniques and medical practices*. Massachusetts, The MIT Press.

Bernard, H.R. (2000) *Social Research Methods*. London, Sage.

Berry, J.M. (2002) 'Validity and Reliability Issues in Elite Interviewing'. *Political science and Politics*, 35: 679-682.

Beswick, J. and White, J. (2003) *Working Long Hours*. Sheffield, HSL.

Bishop, K. (2004) 'Working time patterns in the UK, France, Denmark and Sweden'. *Labour market trends*, Mar: 113-122.

Bishop, M. and Mayer, C. (eds.) (1995) *The Regulatory Challenge*. Oxford, Oxford University Press.

Blair, A., Leopold, J., Karsten, L. (2001) 'An awkward partner? Britain's implementation of the Working Time Directive'. *Time and Society*, 10: 63-76.

Blyton, P. and Turnbull, P. (2004) *The Dynamics of Employee Relations* (3rd ed.) Basingstoke, Palgrave Macmillan.

Bloch, A. (2004) 'Doing Social Surveys'. In C. Seale (ed.) *Researching Society and Culture* (2nd ed) London, Sage.

BMA (2007a) <http://www.bma.org.uk> (Accessed 23/01/07)

BMA (2007b) *Devolution and health policy: a map of divergence within the NHS. First Annual Update*. London, BMA.

BMA (2006a) <http://www.bma.org.uk/ap.nsf/Content/HospitalDoctorsJunHrs> (Accessed 13/01/07).

BMA (2006b) 'Professionalism. Health policy debate – 15 to 30 April 2005' <http://web.bma./org.uk/ap.nsf/Content> (Accessed 13/01/07).

BMA (2004a) 'Background briefing on the Review Body and doctors' pay' < http://www.bma.org.uk/ap.nsf/Content/BackgroundBriefDDRBMarch04> (Accessed 27/7/07).

BMA (2004*b*) *Inquiry into the European Working Time Directive – evidence from the BMA House of Lords Select Committee on the European Union Sub-Committee G.* London, HMSO

BMA (2004*c*) *Doctors leave NHS because they feel unsupported* <http://www.bma.org.uk> Press Release: Wednesday 7 April 2004 (Accessed 15/04/05).

BMA (2004d) *Implementing the European Working Time Directive.* London, BMA.

BMA (2004e) *Flexible Training Forum.* London, BMA.

BMA (2003*a*) *Monitoring of Junior Doctors' Hours – A Case Study Perspective.* London, BMA Health Policy and Economic Research Unit.

BMA (2003*b*) *Hospitals unlikely to meet deadline on junior doctors' hours.* London, BMA <http://www.bma.org.uk> Press Release: Wednesday 30 July (Accessed 22/07/05).

BMA (2003*c*) *BMA responds to DoH guidance on European Working Time Directive.* London, BMA <http://www.bma.org.uk> Press Release: Friday 3 June (Accessed 13/05/04).

BMA (2002) *Pay banding: general guide to the new pay system for junior hospital doctors* <http://www.bma.org.uk> (Accessed 03/01/05).

BMA (2001) *Junior doctors – working conditions* <http://www.bma.org.uk> Press Release: May 2001 (Accessed 11/04/03).

BMA (1999) *Cambridge junior doctors ready to take industrial action.* London, BMA <http://www.bma.org.uk> Press Release 17 September 1999 (Accessed 23/03/01).

Bogg, J., Gibbs, T., Bundred, P. (2001) 'Training, job demands and mental health of pre-registration house officers'. *Medical Education*, 35: 590-595.

Booth, A. and Francesoni, M. (1997) 'Career Mobility in Britain' (ESRC Research Centre on Micro-social Change, Mimeo). In N. Adnett, and S. Hardty, (2001) 'Reviewing the Working Time Directive: rationale, implementation and case law'. *Industrial Law Journal*, 32 (2): 114-125.

Bradshaw, P.L. (2001) 'Politics, power and control in the British National Health Service – will anything really change?' *Journal of Nursing Management*, 9: 311-313.

Branley, D. (2004) 'Doing a Literature Review'. In C. Seale (ed.) *Researching Society and Culture* (2nd ed). London, Sage.

Brown, W., Deakin, S, Ryan, P. (1997) 'The effects of British industrial relations legislation 1979-1997'. *National Institute Economic Review* (161).

Bryman, A. (2001) *Social Research Methods.* Oxford, Oxford University Press.

Bryman, A. (1992) *Mixing Methods: Qualitative and Quantitative Research.' Avebury: Aldershot.* In C. Seal (ed.) (2004) *Social Research Methods A Reader.* London, Routledge.

Bryson, C., Jackson, M., Leopold, J. (1995) 'The impact of self-governing trusts on trades unions and staff associations in the NHS'. *Industrial Relations Journal*, 26 (2): 120-133.

BSA (2002) *British Sociological Association – Statement of Ethical Practice* <http://www.britsoc.co.uk> (Accessed 13 March 2004).

Buchanan, D., Jordan, S., Preston, D., Smith, A. (1997) 'Doctor in the process. The engagement of clinical directors in hospital management'. *Journal of Management in Medicine*, 11 (3): 132-156.

Buell, P. and Breslow, L. (1960) 'Mortality from coronary heart disease in California men who work long hours'. *Journal of Chronic Diseases*, 11: 615-626. In K. Sparks, C.L. Cooper, Y. Fried, A. Shirom (1997) 'The effects of hours of work on health: A meta-analytical review'. *Journal of Occupational and Organizational Psychology*, 70: 391-408.

Burke, R.J. and Richardsen, A.M. (1990) 'Sources of Satisfaction and Stress among Canadian Physicians'. *Psychological Reports*, 67: 1335-1344.

Bussing, A. (1996) 'Social tolerance of working time scheduling in nursing'. *Work & Stress*, 10 (3): 238-250.

Butterfield, P.S. (1988) 'The stress of residency. A Review of the literature'. *Archives of Internal Medicine*, 148: 1428-1433.

Byrne, B. (2004) *Qualitative Interviewing*. In C. Seale (ed) *Researching Society and Culture* (2nd ed). London, Sage.

CBI (2003) 'CBI/Pertemps Employment Trends Survey', cited in COM (2003) 843: 13.

CBI (2000) 'CBI Chief calls on unions to end tug of war over employment laws'. *The CBI Magazine*, 30 Mar.

van de Camp, K., Vernooij-Dassen M.J.F.J., Grol, R.P.T.M., Bottema, B.J.A.M. (2004) 'How to conceptualize professionalism: a qualitative study'. *Medical Teacher*, 26 (8): 696-702.

Caplan, R.P. (1994) 'Stress, anxiety, and depression in hospital consultants, general practitioners, and senior health service managers'. *BMJ*, 309: 1261-1263.

Carr, F. (1999) 'Local bargaining in the National Health Service: new approaches to employee relations'. *Industrial Relations Journal*, 30 (3): 197-211.

Cartwright, K., Lewis, D., Robert C., Bint, A., Nichols, T., Warburton, F. (2002) 'Workload Sand stress in consultant medical microbiologists and virologists: a questionnaire survey'. *The Journal of Clinical Pathology* 2002, Mar, 55(3): 200-205.

Casey, B., Metcalf, H., Millward, N. (1997) *Employer's use of flexible labour*. London, Policy Studies Unit.

Cassidy, C.J. and Griffiths, E. (2004) 'Safety in sleep': anaesthetists, patients and the European Working Time Directive'. *Anaesthesia*, 59: 841.

Catania, J.A., Binson, D., Canchola, J., Pollack, L.M., Hauck, W., Coates, T.J. (1996) 'Effects of interviewer gender, interviewer choice, and item wording on responses to questions concerning sexual behavior'. *Public Opinion Quarterly*, 60: 345-375.

Chartered Institute of Personnel and Development (2001) 'Married to the Job'. *Occupational Health and Safety*, 31: 7.

Chesser, S., Bowman, K. and Phillips, H. 'The European Working Time Directive and the training of surgeons'. *BMJ of Careers Focus*, 31/08/02: 69-70.

Chikwe, J., de Souza, A.C., Pepper, J.R. (2004) 'No time to train the surgeons'. *BMJ*, 328: 418-9.

Clay, H. (1929) *The Problem of Industrial Relations and Other Lectures*. London, Macmillan.

Coburn, D. and Willis, E. (2000) 'The Medical Profession: Knowledge, Power, and Autonomy'. In G.L. Albrecht, R. Fitzpatrick, S.C. Scrimshaw (eds.) *Handbook of Social Studies in Health and Medicine*. London, Sage Publications.

Coburn, D., Rappolt, S. and Bourgeault, I. (1997) 'Decline vs retention of medical power through restratification: an examination of the Ontario case'. *Sociology of Health & Illness*, 19(1): 1-23.

Coburn, D. (1993) 'State Authority, Medical Dominance, and Trends in the Regulation of the Health Professions: The Ontario Case'. *Social Science and Medicine*, 37 (2): 129-138.

Coiera, E. (1996) 'The Internet's challenge to health care provision'. *BMJ*, 312: 3-4.

Cole, R.J., Loving, R.T., Kripke, D.F. (1990) 'Psychiatric aspects of shift work'. *Occupational Medicine*, 5: 310-14.

Commission for Health and Improvement (CHI) (2004) 'National NHS Staff Survey 2003'. London, CHI.

COM (2005) Amended proposal for a Directive of the European Parliament and of the Council amending Directive 2003/88/EC concerning certain aspects of the organisation of working time. 246 Final, 31 May 2005.

COM (2004) Amended proposal for a Directive of the European Parliament and of the Council amending Directive 2003/88/EC concerning certain aspects of the organisation of working time. 607 Final, 22 September 2004.

COM (2003) Communication from the Commission to the Council, the European Economic and Social Committee and the Committee of Regions concerning the re-exam of Directive 93/104/EC concerning aspects of the organization of working time.

COM (2000) State of implementation of Council Directive 93/104/EC of 23 November 1993 concerning certain aspects of the organisation of working time. 787 Final, 1 December 2000.

COM (1997) White Paper on Sectors and Activities Excluded from the Working Time Directive. 334 Final, 15 July 1997.

Cooke, L. and Hutchinson, M. (2001) 'Doctors' professional values: results from a cohort study of United Kingdom medical graduates'. *Medical Education*, 35: 735-742.

Cooper, C.L. (1996) Editorial: Working hours and health. *Work and Stress*, 10: 1-4.

Cooper, C.L., Rout, U., Faragher, B. (1989) 'Mental health, job satisfaction, and job stress among general practitioners'. *BMJ*, 298: 366-370.

Corby, S. (1992) 'Industrial relations developments in NHS trusts'. *Employee Relations*, 14 (6): 33-45.

Cotterill, P. (1992) 'Interviewing women: issues of friendship, vulnerability, and power'. *Women's Studies International Forum*, 15 (5-6): 593-606. In N. Fielding (ed.) *Interviewing Volume III*. London, Sage Publications.

CPC (Cambridge Policy Consultants) (2003) 'Business Impact Assessment – Working Time: Excluded sectors: Supplementary Report: Doctors in Training Final Report'. Cambridgeshire, Newton Hall.

Craig, V. (1998) 'The Working Time Regulations 1998'. *Juridical Review* 1998, 6: 369-377.

Cruess, S.R. and Cruess, R.L. (1997) 'Professionalism must be taught'. BMJ: 1674-77.

Cruess, R.L. and Cruess, S.R. (1997b) Professionalism, laws and kings. *Clin Invest Med* 20(6) 407-13.

Cully, M., Woodland, S., O'Reilly, A., Dix, G. (1999) *Britain at work as depicted by the 1998 Workplace Employee Relations Survey*. London, Routledge.

Dally, P., Ewan, C, Pitney, W.R. (1984) 'Assessment of an Australian medical internship'. *Medical Education*, 5: 301-14.

Dalrymple, T. (2003) 'The patient as office file'. *The New Statesman*, 5 May: 15.

David, M. and Sutton, C. (2004) *Social Research*. London, Sage.

Davies, A.C.L. (2000) 'Don't Trust Me, I'm a Doctor. Medical Regulation and the 1999 NHS Reforms'. *Oxford Journal of Legal Studies*, 20(3): 437-456.

Davies, C. (2004) 'Regulating the healthcare workforce: next steps for research'. *Journal of Health Services & Policy*, 9 (Suppl): 55-61.

Davies, I.H. (2003) 'The future of paediatric training in the United Kingdom – the trainees' perspective'. *Current Paediatrics*, 13: 303-307.

Davies, P.L. and Freedland, M. (1993) *Labour legislation and public policy: a con temporary history*. Oxford, Clarendon Press.

Dash, P. and Jones, A. (1991) 'Stretched to the limit'. *Health Service Journal*, 17 (October): 21-23.

Dawson, S., Mole, V., Winstanley, D., Sherval, J. (1995) 'Management, competition and professional practice: medicine and the marketplace'. *British Journal of Management*, 6 (3): 169-81.

Dawson, S., Willman, P., Clinton, A., Bamford, M. (1988) *Safety at Work: the limits of self-regulation*. Cambridge, Cambridge University Press.

Deakin, S. and Wilkinson, F. (2005) *The Law of the Labour Market*. Oxford, Oxford University Press.

Deakin, S. (2002) 'Equality, non-discrimination, and the labour market: a commentary on Richard Epstein's critique of antidiscrimination laws'. In R.A. Epstein (ed.) *Equal opportunity or more opportunity? The Good thing about discrimination*. London, Institute for the Study of Civil Society.

Deakin, S. (2001) 'The changing concept of the 'employer' in labour law'. *Industrial Law Journal*, 30 (1): 72-84.

Deakin, S. (1999) 'Organisational change, Labour flexibility and the contract of employment in Great Britain'. In S. Deery and R. Mitchell (eds.) *Employment Relations. Individualisation and Union Exclusion*. Annandale (NSW): The Federation Press: Annandale.

Delamothe, T. (1990) 'Juniors favour action over hours'. *BMJ*, 301: 1235.

Dent, M. (2003) *Remodelling hospitals and health professions in Europe: medicine, nursing and the state*. Basingstoke, Palgrave Macmillan.

Dent, M. and Burtney, E. (1996) 'Managerialism and professionalism in general practice: teamwork and the art of "pulling together"'. *Healthpower Manpower Management*, 22 (5): 13-23.

Denzin, N.K. and Lincoln, Y.S. (eds.) (1994) *Handbook of qualitative research. Thousand Oaks*. CA, Sage.

DDRB (Review Body on Doctors' and Dentists' Remuneration) (2006) *Review for 2007*. London, DDRB.

DEFRA (Department of Environment, Food and Rural Affairs) (2007) <http://www.defra.gov.uk/farm/working/agwages/awb/index.htm> (Accessed 03/03/2008)

Department of Health (2007) *Trust, assurance and safety – the regulation of health professionals in the 21st century*. London: DoH.

Department of Health (2006a) *Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients*. London: DoH.

Department of Health (2006b) *NHS Workforce Statistics 1995-2005*. London, The Information Centre < http://www.ic.nhs.uk/pubs/nhsstaff> (Accessed 07/08/07).

Department of Health (2004) *A compendium of solutions to implementing the Working Time Directive for Doctors in Training from August 2004*. London, DoH.

Department of Health (2003a) *Milburn sets out expansion plans for NHS Choice. Press Release* < http://www.dh.gov.uk/en/Publicationsandstatistics/Pressreleases/DH_4024688> (Accessed 03/08/06).

Department of Health (2003b) *Hutton calls on SHA chiefs to secure working time compliance*. <http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases> (Accessed 13/06/05).

Department of Health (2003c) *Guidance on Tackling Junior Doctors' Hours Published Today* <http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases> (Accessed 13/06/05).

Department of Health (2003d) *Guidance on Implementing the European Working Time Directive (EWTD) for Doctors in Training* (HSC 2003/001 Annex 1). London, DoH.

Department of Health (2002a) *Delivering the NHS Plan*. London, DoH.

Department of Health (2002b) *Guidance on Working Patterns for Junior Doctors*. London, DoH.

Department of Health, Welsh Office, Department of Health and Social Services (Northern Ireland), Scottish Home and Health Department (1990). *Heads of Agreement. Ministerial Group on junior doctors' hours*. London, DoH.

Department of Health (1991) *Working for Patients*. London: DoH.

Devadas, D. (2001) 'Short-changed?' *Nursing Times*, 97(37): 27.

Devey, L. (2005) 'Will modernised medical careers produce a better surgeon?' *BMJ*, 331: 1346.

Dickens, R., Machin, S., Manning, A. (1999) 'The effects of minimum wage on employment: theory and evidence from Britain.' *Journal of Labor Economics*, 17(1): 1-22.

Dingwall, R. (eds) (1989) *Socio-legal aspects of medical practice*. London: Royal College of Physicians.

Dillner, L. (1993) 'Senior house officers: the lost tribes'. *BMJ*, 307: 1549-1551.

Doyal, L. and Cameron, A. 'Reshaping the NHS Workforce: necessary changes are constrained by professional structures from the past'. *BMJ*, 320: 1023.

DTI (1996) *A Consultation Document on Measures to Implement Provisions of the EC Directive on the Organisation of Working Time ('The Working Time Directive')*. London, DTI.

DTI (1998a) *Fairness at Work*. Cm 3968. London, DTI.

DTI (1998b) *Regulatory Guidance: Working Time Conditions*. London, DTI.

DTI (2002a) *UK workers struggle to balance work and quality of life as long as hours and stress take hold.* Press Release: 30 August 2002 <http://164.36.164.20/work-lifebalance/press300802.html> (Accessed 6 May 2004).

DTI (2002b) *Measures to Implement Directive 2000/34/EC of the European Parliament and of the Council, Amending Council Directive 93/104/EC Concerning Certain Aspects of the Organisation of Working Time to Cover Sectors and Activities Excluded from that Directive.* London, DTI.

Dula, D.J., Dula, N.L., Hamrick, C., Wood, G.C. (2001) 'The effect of working serial night shifts on the cognitive functioning of emergency physicians'. *Ann Emer Med*, 38: 153-5

Earnshaw, J. and Cooper, C. (1994) *Stress and Employer Liability*. London, Institute of Personnel and Development.

Eckstein, H. (1958) *The English Health Service*. Cambridge, Cambridge University Press.

Economist (2003) 'Another Headache; Doctors. Junior doctors' hours'. The Economist (US) July 19, 368 (8333): 44.

Edelman, L.B. (1992) 'Legal Ambiguity and Symbolic Structures: Organisational Mediation of Civil Rights Law'. *American Journal of Sociology*, 97: 1531-76.

Edwards, N. (2003) 'Beat the clock'. *Health Service Journal*, 10 July: 24-25.

EIRO (2004a) *Working time developments – 2003*. Dublin, European Foundation for the Improvement of Living and Working Conditions.

EIRO (2004b) 'EU Directive drives reform of junior doctors' working hours' <www.eiro.eurofound.eu.int/2004/04/feature/uk0404105f.html> (Accessed 09/09/04).

EIRO (1999) 'Commission proposes Directive to end exclusion of sectors from working time Directive' <http://www.eiro.eurofound.eu.int/1999/01/feature/eu9901144f.html>> (Accessed 09/09/04).

EIRR (2002) 'Continuing upward trend in union recognition'. March, 14-17.

EIRR (1998) 'Trends in public sector union membership'. June, 21-23.

Elliot, P. (1972) *The Sociology of the Professions*. London, Macmillan.

Epstein, R.A. (2002) *Equal opportunity or more opportunity? The Good thing about discrimination*. London, Institute for the Study of Civil Society.

Equal Opportunities Review (2003) *Flexible training essential for NHS*. London, EOC.

European Foundation for the Improvement of Living and Working Conditions (Eurofound) (2007) *Working Time Developments – 2006*. Dublin, Eurofound.

Evans, A. and Palmer, S. (1985) *Negotiating Shorter Hours*. London, Macmillan Press.

Evans, J., Lee, P. Goldacre, M.J., Lambert, T.W. (2004) 'Pre-registration house officers' comments on working in the NHS: a qualitative study of the views of UK medical graduates of 1999'. *Medical Teacher*, 26 (3): 250-255.

Evetts, J. (1998) 'Professionalism beyond the Nation-State: International systems of professional regulation in Europe'. *International Journal of Sociology and Social Policy*, 18 (11/12): 47-64.

Ewing, K. (eds) (1996) *Working Life: A new perspective on labour law*. London, Institute of Employment Rights.

Exworthy, M. and Halford, S. (1999) *Professionals and the New Managerialism in the Public Sector*. Buckingham, Open University Press.

Farnham, D. and Horton, S. (1996) (eds) 'Managing the new Public Services' (2nd ed). Hampshire: Mac,millan Press.

Farnham, D. and Horton, S. (1993) The new public service managerialism: an assessment. In D. Farnham and S. Horton (eds.) *Managing the new public management*. Basingstoke. Macmillan.

Fajertag, G. (1998) 'Working Time in Europe: Current trends'. In J. Wheelock and J. Vail (eds.) *Work and Idleness: The Political Economy of Full Employment*. Dordrecht, Kluwer Academic Publishers.

Feldman. M.S., Bell, J., Berger, M.T. (2003) *Gaining Access A Practical and theoretical guide for qualitative researchers*. Oxford: Altamira Press.

Ferlie, E., Ashburner, L., Fitzgerland L. and Pettigrew, A. (1996) *The new public management in action*. Oxford, Oxford University Press.

Ferri, E. and Smith, K. (1996) *Parenting in the 1990s*. London, Family Policy Studies Centre.

Finch, J. (1984) "It's great to have someone to talk to": The ethics and politics of interviewing women. In C. Bell and H. Roberts (eds.) *Social researching: Politics, problems, practice*. London, Routledge and Kegan Paul.

Firth, J. (1986) 'Levels and sources of stress in medical students'. *BMJ*, 292: 1177-1180.

Firth-Cozens, J. (1987) 'Emotional Distress in junior house officers'. *BMJ*, 295: 533-536.

Fitz, J. and Halpin, D. (1995) "Brief encounters": researching education policy-making in elite settings. In J. Salisbury and S. Delamont (eds.) *Qualitative studies in education*, Avebury, Aldershot: 65–86.

Fitzpatrick, B. (1997) 'Straining the Definition of Health and Safety'. *Industrial Law Journal*, 26 (2): 115-135.

Flynn, N. (1993) *Public sector management* (2nd ed.) Hemel Hampstead, Harvester Wheatsheaf.

Flynn, R. (1999) Managerialism, professionalism and quasi-markets. In M. Exworthy and S. Halford (eds.) *Professionals and the New Managerialism in the Public Sectors*. Buckingham, Open University Press.

Forlin, G. (eds.) (2003) *Corporate Liability Work Related Deaths and Criminal Prosecutions*. London, Lexis Nexis Butterworths.

Forster, D.P., Frost, C.E.B., Morris, D. (1986) Performance indicators in health service management – a clinical analogy'. *Hospital Services Review*, 82 (4): 167-70.

Forsyth, M., Calnan, M., Wall, B. (1999) 'Doctors as patients: postal survey examining consultants and general practitioners adherence to guidelines'. *BMJ*, 319: 605-608.

Foster, P. and Wiling, P. (2000) 'Whither Welfare Professionalism?' Social *Policy & Administration* 34 (2): 143-59.
Fox, R. (2007) 'An examination of the UK labour market for doctors'. *Institute of economic affairs* March: 58.

Frauenfelder, C. (2006) 'NHS needs more consultant surgeons to cope with demand'. *BMJ*: 1141.

Freidson, E. (1994) *Professionalism Reborn: Theory, Prophecy, and Policy*. Cambridge, Polity Press.

Freidson, E. (1988) *Profession of medicine: a study of the sociology of applied knowledge, with a new afterword*. Chicago, University of Chicago Press.

Freidson, E. (1983) 'The Theory of Professions: State of the Art'. In R. Dingwall and P. Lewis (eds.) *The Sociology of the Professions Lawyers, Doctors and Others*. London, Macmillan Press.

Freidson, E. (1970a) *Professional Dominance*. New York, Atherton.

Freidson, E. (1970b) *Profession of Medicine: A study of the Sociology of Applied Knowledge*. New York, Dodd, Mead & Co.

Furst, L. (1998) *Between Doctors and Patients*. Virginia, University Press of Virginia.
Gall, G. (2004) 'Trade union recognition in Britain, 1995-2002: turning a corner?' *Industrial Relations Journal*, 35: 249-270.

Geertz, C. (1983) *Local Knowledge: Further essays on interpretive anthropology*. New York, Basic Books.

GMC (1998) *The New Doctor: Supplement on General Clinical Training in General Practice*. London, GMC.

GMC (1997) *The New Doctor*. London, GMC.

Gillard, J.H., Dent, T.H.S., Aarons, E.J., Smyth-Pigott, P.J., Nicholls, M.W.N. (1993) 'Preregistration house officers in eight English regions: survey of quality of training'. *BMJ*, 307: 1180-1184.

Ginsburg, S., Kachan, N., Lingard, L. (2005) 'Before the white coat: perceptions of professional lapses in the pre-clerkship'. *Medical Education*, 39: 12-19.

Glasbeek, H.J. (1984) 'Why Corporate Deviance is not treated as a Crime – They Need to Make "Profits" a Dirty Work'. *Osgood Hall Law Journal*, 22: 393-439.

Glasbeek, H.J. and Rowland, S. (1979) 'Are Injuring and Killing at Work Crimes?' *Osgood Hall Law Journal*, 17: 506-594.

Godlee, F. (2005) 'More miles, fewer biscuits'. *BMJ*: 330.

Goldacre, M.J., Davidson, J.M., Lambert, T.W. (1999) 'Career choices at the end of the pre-registration year of doctors who qualified in the UK in 1996'. *Medical Education*, 33: 882-9.

Goldberg, I. and Buckley, G. (1998) 'Flexibility training and flexible working in the European Union'. *Medical Education*, 32 (2): 113-15.

Goldberg, I. and Maingay, J. (1997) 'Eligible for flexible training?' *BMJ*: 23.

Gorissen, W., Schulpen, T., Kerkhoff, A, van Heffen, O. (2005) 'Bridging the gap between doctors and policymakers'. *European Journal of Public Health*, 15 (2): 133-139.
Gould, M. (2002) 'Smaller trusts face huge problems with the "new deal"'. *BMJ* (325): 458.

Grabosky, P.N. (1995) 'Regulation by Reward: On the Use of Incentives as Regulatory Instruments'. *Law and Policy*, 17: 256-281.

Grabosky, P.N. and Braithwaite, J. (1986) *Of manner's gentle: enforcement strategies of Australian business regulatory agencies*. Melbourne, Oxford University Press.

Grainger, C. and Harries, E. (1995) 'New deal shifts may increase house officers' stress'. *BMJ*, 311: 952-53.

Grant, L., Simpson, L.A., Rong, X.L., Peters-Golden, H. (1990) 'Gender, Parenthood, and Work Hours of Physicians'. *Journal of Marriage and the Family*, 52: 39-49.

Gray, A. (2003) *Research Practice for cultural studies*. London, Sage.

Greenwood, E. (1957) 'Attributes of a profession', *Social Work*, 2 (3): 44-55.

Greenwood, J. (2003) *Interest Representation in the European Union*. Basingstoke, Palgrave Macmillan.

Greer, S.L. (2005a) *The new EU health policy and the NHS systems*. London, The Nuffield Trust.

Greer, S.L. (2005b) Europe, Whitehall, and Devolution: Multi-level politics and health policy in the devolved UK. In A. Trench (ed.) *The State of the Nations 2005*. Exeter, Imprint.

Greer, S.L. (2005c) 'The politics of health-policy divergence.' In Adams, J. and Schmueker, K. (eds) *Devolution in Practice*. Newcastle, Institute for Public Policy Research.

Greer, S.L. (2006) *Responding to Europe. Government, NHS and Stakeholder responses to the EU Health policy challenge*. London, The Nuffield Trust.

Griffiths Report (1983) *NHS Management Inquiry*. London, DHSS.

Groves, R.M. and Fultz, N.H. (1985) Gender effects among telephone interviewers in a survey of economic attitudes. *Sociological methods & Research*, 14: 31-52, quoted by Shuy, R.W. (2001) In-person versus telephone interviewing. In J.F. Gubrium and J.A. Holstein (eds.) CA, Sage Publications.

Guardian, The, 'The 'Life in the NHS: violence, stress – and pride'. Carvel, J. March 10, 2004.

Guerts, S., Rutte, C., Peeters, M. (1999) 'Antecedents and consequences of work-home interference among medical residents'. *Social Science & Medicine*, 48: 1135-48.

Gunningham, N. and Grabosky, P. (1998) *Smart Regulation Designing Environmental Policy*. Oxford, Oxford University Press.

Gunningham, N. and Rees, J. (1997) 'Industry Self-Regulation: An Institutional Perspective'. *Law and Policy*, 19 (4): 363-414.

Haas, J. and Shaffir, W. (1987) *Becoming Doctors: The Adoption of a Cloak of Competence*. Connecticut, Jia Press.

Hadley, R. and Forster, D. (1995) Where the reforms did not reach: doctors as front line managers. *Journal of Management in Medicine*, 9 (5): 27-38.

Hafferty, F.W. and Light, D.W. (1995) Professional Dynamics and the Changing Nature of Medical Work. *Journal of Health and Social Behavior*, 132-153.

Haines, F. and Gurney, D. (2003) 'The Shadows of the Law: Contemporary Approaches to Regulation and the Problem of Regulatory Conflict'. *Law and Policy*, 25 (4): 353-380.

Hale, R. and Hudson, L. (1992) 'The Travistock study of young doctors: report of the pilot phase'. *British Journal of Hospital Medicine*, 47(6): 452-463.

Hansard 1996 col. 782.

Hansard 1991-1992 col. 536

Ham, C. (2004) *Health Policy in Britain* (5th ed.). Hampshire, Palgrave Macmillan.

Ham, C. (1994) *Management and competition in the new NHS.* Oxford and New York, Radcliffe Medical Press.

Ham, C. (1992) Health Policy in Britain (3rd ed.). Basingstoke, Macmillan.

Hammersley, B. and Atkinson, P. (1995) *Ethnography: Principles in Practice* (2nd ed). London, Routledge.

Hannigan (1998) Assessing the new public management: the case of the National Health Service. *Journal of Nursing Management*, 6 (5): 307-12.

Hantrais, L. (2000) *Social Policy in the European Union* (2nd ed.) London, Macmillan Press.

Hardwidge, C. (2002) Jobs in the public and private sectors. *Economic Trends* (1), 582: 39-52.

Hardy, G.E., Shapiro, D.A. Borrill, C.S. (1997) 'Fatigue in the workplace of national health service trusts'. *Journal of Psychosomatic Research* (43): 83-92.

Hardy, S. and Adnett, N. (1999) 'Entrepreneurial Freedom versus Employee Rights: The Acquired Rights Directive and EU Social Policy Post-Amsterdam'. *Journal of European Social Policy*, 9 (2): 127-137.

Harrington, J.M. (1994) 'Working long hours and health'. *BMJ*, 308: 1581-1582.

Harrison, S. and Ahmad, W.I.U. (2000) 'Medical Autonomy and the UK State 1975 to 2025'. *Sociology* (1): 129-146

Harrison, S. and Wood, B. (1999a) 'Designing Health Service Organisation in the UK, 1968 to 1998: From Blueprint to Bright Idea and 'Manipulated Emergence'. *Public Administration*, 4: 751-768.

Harrison, A. (1999b) Serving the Consumer. In J. Appleby and A Harrison, A. (eds.) (2000) *Health Care UK The King's Fund review of health policy.* London, King's Fund Publishing.

Harrison, S. and Pollitt, C. (1994) *Controlling Health Professionals.* Buckingham, Open University Press.

Hart, R.A. (1987) *Working Time and Employment*. Boston, Allen and Unwin.

Haug, M.R. (1973) 'Deprofessionalization: an alternative hypothesis for the future'. *Soc Rev Monog* (20): 195-211.

Haug, M.R. (1983) 'A re-examination of the hypothesis of physician deprofessionalization'. *Millbank Q*, 66 (Suppl 2): 48-56.

Hawkins, K. (1984) *Environment and Enforcement Regulation and the Social Definition of Pollution*. Oxford, Clarendon Press.

Held, D. (1995) *Democracy and the Global Order: From the Modern State to Cosmopolitan Governance*. Cambridge, Polity Press.

Held, D. (2000) *Models of Democracy* (2nd ed.) Cambridge, Polity.

Held, D. (2002) 'Law of States, Law of Peoples: Three Models of Sovereignty'. *Legal Theory*, 8: 1-44.

Hellawell, G.O, Kahn, L., Mumtaz, F. (2005) 'The European working time directive: implications for subspecialty acute care'. *Journal of Clinical Practice*, 59 (5): 508-510.

Hertz, R. and Imber, J.B (1993) Fieldwork in elite settings: introduction. *Journal of Contemporary Ethnography* 22 (1): 3–6.

Hicks, S., Walling, A., Heap, D., Livesey, D. (2005) *Public Sector Employment Trends 2005*, Labour Market Division and Employment of Earnings and Productivity Division. London, Office of National Statistics.

Hilton, S.R. and Slotnick, H.B. (2005) 'Proto-professionalism: how professionalisation occurs across the continuum of medical education'. *Medical Education*, 39: 58-65.

Hobbs, R. and Njoya, W. (2005) Annual Review Article 2004. Regulating the European labour market: prospects and limitations of a reflexive governance approach. *British Journal of Industrial Relations*, 43 (2): 297-319.

Hofgastein, B and Richards, T. (2006) EU seeks views on patients' rights to care across borders. *BMJ*, 333: 773.

Hoggett, P. (1996) 'New Modes of Control in the Public Service'. *Public Administration*, 74: 9-32.

Hood, C., James, O., Scott, C. (2000) 'Regulation of Government: Has it increased, is it increasing, should it be diminished?' *Public Administration*, 78 (2): 283-304.

Hood, C. and Scott, C. (1996) 'Bureaucratic regulation and new public management in the United Kingdom: mirror-image'. *Journal of Law and Society*, 23: 321-345.

Hornby, A.S. Cowie, A.P, Gimson, A.C. (eds.) (1983) *Oxford Advanced Learner's Dictionary*. Oxford, Oxford University Press.

Houston, D.M. and Allt, S.K. (1997) 'Psychological distress and error making among junior house officers'. *British Journal of Health Psychology*, 2: 141-151.

Huddy, L., Billig, J., Bracciodieta, J., Lois, H., Moynihan, J., Pugliani, P. (1997) 'The effect of interviewer gender on the survey response'. *Political Behavior*, 19 (3): 197-220.

Hughes, D. (1989) Regulating the use of NHS resources: organisation. In R. Dingwall (eds) *Socio-legal aspects of medical practice*. London, Royal College of Physicians.

Hunt, A. (1993) *Explorations in Law and Society: Toward a Constitutive Theiry of Law*. New York, Routledge.

Hunt, E.H. (1981) *British Labour History 1815-1914*. Bath, Pitman Press.

Hunter, D.J. (1994) From tribalism to corporatism: the managerial challenge to medical dominance. In J. Gabe, D. Kelleher, G. Williams (1994) *Challenging Medicine*. London, Routledge.

Hunter, D.J. (1992) Doctors as managers: poachers turned gamekeepers? *Social Science and Medicine*, 35 (4): 557-66.

Hunter, S. (1991) 'Commitment vital for new deal'. *BMJ*, 303: 840-841.

Huntingham, M.J. (1957) The Development of a professional self-image. In R.K. Merton, G. Reader, P. Kendall (1957) *The student-physician*. Cambridge, Massachusetts: Harvard University Press.

Hutchinson, K. (1994) Trade union recognition. *Health Manpower Management*, 20 (3): 25-29.

Hutter, B.M. (1997) 'Compliance: Regulation and Environment'. Oxford, Clarendon Press.

Hutter, B.M. (1993) 'Regulating Employers and Employees: Health and Safety in the Workplace'. *Journal of Law & Society*, 20 (4): 452-470.

Huyse, L. and Parmentier, S. (1990) 'Decoding Codes: The dialogue between consumers and suppliers through Codes of Conduct in the European Community'. *Journal of Consumer Policy*, 13: 253-272.

Hyman, H.H Cobb, W.J. Feldman, J.J. Hart C.W, Stember, C.H. (1954) Interviewing in Social Research. In C. Seal (ed.) (2004) *Social Research Methods A Reader*. London, Routledge.

Irvine, D. (2006) 'A short history of the General Medical Council'. *Medical Education*, 40: 202-11.

Irvine, D. (1997) 'The performance of doctors. i: professionalism and self regulation in a changing world'. BMJ: 1540.

Jessop, B. (1997) 'Capitalism and its future: remarks on regulation, government and governance'. *Review of International Political Economy*, 4 (3) 561-581.

Johnson, J.M. (2001) In-Depth Interviewing. In J.F. Gubrium and J.A. Holstein (eds.) *Handbook of Interview Research. Context and Method.* CA, Sage Publications.

Johnson, T. (1972) *Professions and Power.* London, MacMillan.

Jolly, B. (2001) 'Modernising regulation in the health professions'. *Medical Education*, 35: 1095.

Jones, P.P. (1981) 'Membership of associations and free-riders'. *Industrial Relations Journal*, 12 (6): 34-44.

Jones, P.R. (1974) 'The British Medical Association and the closed shop'. *Industrial Relations Journal*, 5 (4): 36-45.

Jones, S. (2004) Depth Interviewing. In C. Seal (ed.) (2004) *Social Research Methods A Reader.* London, Routledge.

Kagan, P. and Scholz, J. (1984) On Regulatory Inspectorate and Police. In K. Hawkins and J. Thomas (eds.) *Enforcing Regulation.* Boston, Kluwer-Nijhoff.

Kendall, I., Moon, G., North, N., Horton, S. (1996) The National Health Service. In D. Farnham and S. Horton (eds.) *Managing the new public services* (2nd ed). Basingstoke, Macmillan.

Kirk, J. and Miller, M.L. (1986) Reliability and Validity in Qualitative Research. Quoted in Bryman, A. (2001) *Social Research Methods.* Oxford, Oxford University Press.

Kirkpatrick, I., Ackroyd, S., Walker, R. (2005) *The new managerialism and public service professions: change in health, social services, and housing.* London, MacMillan

Kirk-Smith, M.D. and Stretch, D.D. (2003) 'The influence of medical professionalism on scientific practice'. *Journal of Evaluation in Clinical Practice*,' 9 (4): 417-422.

Klein, R. (1998) 'Competence, professional self regulation, and the public interest'. *BMJ*, 316: 1740.

Kmietowicz, Z. (2007) 'Doctors threaten to withdraw subscriptions to GMC if they are not allowed to regulate themselves'. *BMJ*, 335: 14.

Kmietowicz, Z. (2005) 'Medical professionalism is under threat, say eight in 10 aspiring British doctors'. *BMJ*, 331: 1292.

Kneebone, R. and Darzi, A. (2005) 'New professional roles in surgery'. *BMJ*, 330: 803-804.
Klein, R. (1998) 'Clinical depression'. *The Guardian,* April 29th: p 7.

Klein, R. (2002) 'Governance for NHS trusts'. *BMJ*, 326: 174-5.

Kapur, N., Appleton, K., Neal, R. (1999) 'Sources of job satisfaction and psychological stress in GPs and medical house officers'. *Family Medicine*, 16(6): 600-1.

Kapur, N. and House, A. (1998) 'Working patterns and the quality of training of medical hours officers: evaluating the effect of the 'new deal''. *Medical Education*, 32: 432-438.

Kapur, N. and House, A. (1997) 'Job satisfaction and psychological morbidity in medical house officers'. *Journal of the Royal College of Physicians of London*, 31: 162-7.

Kenner, J. (2004) 'Re-evaluating the concept of working time: an analysis of recent case law'. *Industrial Relations Journal*, 35 (6): 588-602.

Kirkaldy, B.D., Bruce, Trimpop R., Rudiger, Levine, Robert, (2002) 'The impact of work hours and schedules on the physical and psychological well-being in medical pratices'. *European Psychologist*, 7(2): 116-124.

Kodz, J., Davis, S., Lain, D., Strebler, M., Riock, J., Bates, P., Cummings, J., Meager, N., Anxo, D., Gineste, S., Trinczek, R., Palmer, S. (2003) *Working Long Hours: A Review of the Evidence*. DTI Employment Relations Research series, No 16. London, DTI.

Kuhn, J.W. (1961) 'Right-to-Work Laws – Symbols or Substance?' *Industrial and Labor Relations Review*, 14 (4): 587-594.

Kvale, S. (1996) *Interviews: An introduction to qualitative research interviewing*. CA, Sage Thousand Oaks.

Labour Party (1995) *Renewing the NHS: Labour's agenda for a healthier Britain*. London: Labour Party.

Lambert, T.W., Goldacre, M.J., Evans, J. (2000) 'Views of junior doctors about their work: survey of qualifiers of 1993 and 1996 from United Kingdom medical schools'. *Medical Education*, 34: 348-54.

Landers, R., Rebitzer, J., Taylor, L. (1996) 'Rat Race Redux: Adverse Selection in the Determination of Work Hours in Law Firms'. *American Economic Review*, 86 (3): 329-348.

Larkin, G.V. (1993) 'Continuity in Change: Medical dominance in the United Kingdom'. In F.W. Hafferty and J.B. McKinlay (eds.) *The Changing Medical Profession*. Oxford, Oxford University Press.

Larson, M.S. (1977) *The rise of Professionalism: A Sociological Analysis*. London, University of California Press.

Learmonth, M. (1997) 'Managerialism and public attitudes towards UK NHS managers'. *Journal of Management in Medicine*, 11 (4): 214-221.

Legrand, P. (1995) 'Comparative Legal Studies and Commitment to Theory'. *Modern Law Review*, 58: 262-273.

Legrand, P. (1997) 'Against a European Civil Code'. *Modern Law Review*, 60(1): 44-63.

Leslie, P.J., Williams, J.A., McKenna, C., Smith, G., Heading, R.C. (1990) 'Hours, volume, and type of work of preregistration house officers'. *BMJ*, 300: 1038-1041.

Lewis, J. (2003) Design issues. In J. Ritchie and J. Lewis (eds.) *Qualitative Research Practice*. London, Sage.

Lilleker, D.G. (2003) 'Doing Politics. Interviewing the Political Elite: Navigating a Potential Minefield'. *Politics*, 23 (3): 207-214.

Linn, L.S., Yager, J., Cope, D., Leake, B. (1985) 'Health status, job satisfaction and life satisfaction among academic and clinical faculty'. *Journal of the American Medical Association*, 254: 2775-2782.

Lissauer, R. (2002) 'The future workforce'. *BMJ Career Focus*, 325: 7363.
Lloyd, C. (1997) 'Decentralization in the NHS: Prospects for workplace unionism'. *British Journal of Industrial Relations*, 35 (3): 427-446.

Low Pay Commission (2003) *The National Minimum Wage. First Report of the Low Pay Commission*. London, LPC.

Lowry, S. (1993) 'The preregistration year'. *BMJ*, 306: 196-198.

Lupton, D. (1997) 'Doctors on the medical profession'. *Sociology of Health and Illness*, 19 (4): 480-497.

McGuire, A. (1989) Regulating the use of NHS resources: an economic perspective. In R. Dingwall (ed.) *Socio-legal aspects of medical practice*. London, Royal College of Physicians.

McHugh, J. (1994) The Lords' will be done: interviewing the powerful in education. In G. Walford (ed.) *Researching the Powerful in Education*. London, University College London Press.

McIvor, A.J. (1987) 'Employers, the government, and industrial fatigue in Britain, 1890-1918'. *British Journal of Industrial Medicine*, 44: 724-732.

McIvor, A.J. (2001) *A History of Work in Britain 1880-1950*. London, Palgrave.

McKee, M. and Black, N. (1992) 'Does the current use of junior doctors in the United Kingdom affect the quality of medical care?' *Social Science & Medicine*, 34(5): 549-588.

McKinlay, J.B. (1982) 'Towards prolterianization of physicians'. In Derber, E. (ed) *Professionals as workers: mental labor in advanced capitalism*. Boston: G.K. Hall (1982) pp. 37-62.

McKinlay, J.B. and Marceau, L.D. (2002) 'The end of the Golden Age of Doctoring.' *International Journal of Health Services*, 32(2): 379-416.

McManus, I.C., Lockwood, D.N., Cruickshank, J.K. (1977) 'The preregistration year. Chaos by consensus'. *The Lancet*: 413-417.

McMullen, J., Brewer, M., Curtis, P. (2001) *Working Time Law and Practice*. London, Sweet & Maxwell.

MacDonald, R. (2003) 'More doctors is not the answer to the EU Working Time Directive' (News), *Student BMJ* (Feb): 5.

Macdonald, K.M. (1995) *The Sociology of the Professions*. London, Sage.

MacErlean, N. 'Long hours: a sign of poor practice'. *The Lawyer*, October 1998, 11.

Majone, S. G. (1996) *Regulating Europe*. London, Routledge.

Makkai, T. and Braithwaite, J. (1993) 'Praise, Pride and Corporate Compliance'. *International Journal of the Sociology of Law*, 27: 73-91.

Mason, J. (1996) *Qualitative researching*. Sage, London.

Mather, H. and Pounder, R.E. (2004) *Coping with problems in acute medicine post-WTD era – a survey of RCP College Tutors*. London, RCP.

Mather, H.M. (2002a) 'The Royal College of Physicians specialist registrar shift survey.' *Hospital Medicine*, 63 (7): 429-431.

Mather, H.M. (2002b) 'Royal College of Physicians Trainees Committee. The Royal College of Physicians specialist registrar survey'. *Hospital Medicine*, 63 (7): 429.

Marron, C.D., Byrnes, C.K., Kirk, S.J. (2005) 'An EWTD-compliant shift rota decreases training opportunities'. *Royal College of Surgeons Bulletin*, 87: 246-246.

Martino, V. Di (1995) 'Megatrends in working time'. *Journal of European Social Policy*, 5(3): 235-249.

May, T. (2001) *Social Research Issues, methods and process* (3rd ed.). Birmingham, Open University Press.

Merllie, D. and Paoli, P. (2000) *Ten years of working conditions in the European Union*. Dublin: European Foundation of Living and Working Conditions.

Merton, R.K., Reader, G., Kendall, P. (1957) *The Student Physician*. Cambridge, Massachusetts, Harvard University Press.

Merrison Committee (1975) *Report of the Committee of Inquiry into the Regulation of the Medical Profession* (Cmnd 6018). London, HMSO.

Miettinen, O.S. and Flegel, K.M. (2003) 'Elementary concepts of medicine: X. Being a good doctor: professionalism'. *Journal of Evaluation in Clinical Practice*, 9 (3): 341-344.

Miles, A., Baldwin, T., Charter, D. (2002) 'Heart surgeons stall Blair's drive to slash waiting lists', *The Times* (June 2002: 13:1). In R. Rosen 'Recruiting overseas doctors'. *BMJ* (325): 290.

Millard, B. and Machin, A. (2007) 'Characteristics of public sector workers'. *Economic & Labour Market Review*, 1(5): 46-55.

Millward, N., Bryson, A., Forth J. (2000) *All change at work? British Employment Relations 1990-1998, as portrayed by the Workplace Industrial Relations Survey Series.* London, Routledge.

Millward, N. and Stevens, M. (1986) *British Workplace Industrial Relations 1980-1984. The DE/ESRC/PSI/ACAS Surveys.* Hants, Gower Publishing Company Ltd.

Molloy, M.S. (2003) 'Directive will be biggest drive for change in delivery of medical care'. *BMJ*, 326: 929-930.

Moran, M. and Wood, B. (1993) *States, Regulation and the Medical Profession.* Buckingham, Open University Press.

Morrice, J.K.W. (1984) 'Job stress and burnout'. *Bulletin of the Royal College of Psychiatrists*, 8: 45-46. In A. Spurgeon and J.M. Harrington (1989) 'Work performance and health of junior hospital doctors – a review of the literature'. *Work & Stress*, 3(2): 117-128.

Moser, C. and Kalton, G. (1971) 'Survey Methods in Social Investigation' (2nd ed.). Aldershot, Gower. In C. Seal (ed.) (2004) *Social Research Methods A Reader.* London, Routledge.

Moss, P., Reid, N., Jackson, S., Lam, F., Morris, D. (1996) *The working hours, working patterns, stress levels and views of house officers – A study of a general surgical department, Part one of a Report to the West Midlands Regional Task Force (Doctors in Training).* Coventry, Coventry University.

Moss, P.J., Lambert, T.W, Goldacre, M.J., Lee, P. (2004) 'Reasons for considering leaving UK medicine: Questionnaire study of junior doctors' comments'. *BMJ*, 329: 1263-1265.
Napier, B.W. (1991) 'Working Time and the Law'. *New Law Journal*: 1667-69.

Neathey, F., Arrowsmith, J. (1999) *Early implementation of the Working Time Regulations.* London, DTI.

Nettleton, S. and Harding, G. (1994) 'Protesting patients: a study of complaints submitted to a Family Health Service Authority'' *Sociology of Health and Illness*, 16 (1): 38-61.

Northrop J. and Hearn, K. (1998) 'Minute Stakes'. *Health Service Journal*, 5 (November): 28-30.

NHS Management Executive (1991) *Junior Doctors. The New Deal.* London, NHS Management Executive.

Nasmyth, D.G., Pickersgill, A., Hogarth, M. (1991) 'Reducing hours of work of preregistration house officers: report on a shift system'. *BMJ*, 302: 93-94.

Neathey, F., Arrowsmith, J. (2001) 'Implementation of the Working Time Regulations', *Employments Research Series* 11, DTI <http://www.dti.gov.uk/er/emar/wtr.pdf> (Accessed 03/03/04).

Neathey, F. (2003) 'Implementation of the Working Time Regulations: follow up study' <<http://www.dti.gov.uk/er/emar/errs19.pdf>> Accessed 3 March 2004.

Newman, K., Pyne, T., Cowling, A. (1996) 'Junior doctors and management: myth and reality.' *Health Manpower Management*, 22 (1): 32.

Newman, M. (2005) 'Fears mount for juniors training'. *Hospital Doctor* 27 (January) <http://www.hospital-doctor.com> (Accessed 07/04/05).

Newton J. (1997) 'Employment relations in small service organizations'. *Employee Relations*, 19 (1): 67-80.

Nicholson, P.J. (2002) 'Occupational health in the European Union'. *Occupational Medicine*, 52 (2): 80-84.

North West Wales NHS Trust (2002) *Effects of the European Working Time Directive on Junior Doctors in Wales*. North West Wales NHS Trust.

NWP (2006) 'Surviving the night shift – a guide for junior doctors'. *Calling Time*. London, NWP.

NWP (2005) 'Working Time Directive 2009 – three years to go but the work starts now'. *Calling time*. London, NWP.

Oakley, A. (1981) 'Interviewing women: A contradiction in terms'. In H. Roberts (ed.) *Doing Feminist research*. London, Routledge.

Padfield, M. and Procter, I. (1996) The effect of interviewer's gender on the interviewing process: a comparative enquiry. *Sociology*, 30: 355-66. Cited in S. Reinharz and S.E. Chase (2001) *Interviewing Women*. In J.F. Gubrium and J.A. Holstein (eds.) *Handbook of Interview Research*. CA, Sage.

Paice, E. and Reid, W. (2004) 'Can training and service survive the European Working Time Directive?' *Medical Education*, 38: 336-339.

Paice, E. (1998) 'Is the New Deal compatible with good training? A survey of senior house officers'. *Hospital Medicine*, 59(1): 72-74.

Palmer, T., Gainger, H., Fitzner, G. (2004) *Trade Union Membership 2003*. London, DTI.

Palmer, T. (2004) *Results of the first flexible working employee survey*. London, DTI.

Panayiotou, B.N. and Fotherby, M.D. (1996) 'Junior hospital doctors' views on their training in the UK'. *Postgraduate Medical Journal*, 72: 547-50.

Pearce, F. (1990a) ''Responsible Corporations' and regulatory agencies'. *Political Quarterly*, 61 (4): 415-30.

Pearce, F. (1990b) 'Ideology, Hegemony, and Empiricism Compliance Theories of Regulation'. *British Journal of Criminology*, 30 (4): 423-443.

Petersen, L.A., Brennan, T.A., O'Neill, A.C, Cooke, F.E., Lee, T.H. (1994) 'Does house staff discontinuity of care increase the risk for preventable adverse events?' *Ann International Medicine*, 121: 866-72.

Philip, L. (1998) 'Combining quanitative and qualitative approaches to social research in human geography – an impossible mixture?' *Environment and Planning*, 30: 261-76. In C. Seale (ed.) (2004) *Researching Society and Culture* (2nd ed.) London, Sage.

Phillip, H., Fleet, Z. and Bowman, K. (2003) *The European Working Time Directive – Interim Report on Guidance from the Royal College of Surgeons of England Working Party.* London, Royal College of Surgeons.

Phillips, R. (1998) 'The Politics of History: some methodological dilemmas in elite-based research'. *British Educational Research Journal*, 24 (1): 5-19.

Pickersgill, T. (2001) 'The European Working Time Directive for doctors in training'. *BMJ*, 323: 1266.

Pickersgill, T. and Cross, J. (1999) 'Representing your colleagues'. *BMJ*, 319: 2.
Pollack, M.A. (2003) *The Engines of European Integration.* Oxford, Oxford University Press.

Pollitt, C. (1993) *Managerialism and the Public Services* (2nd ed.). Oxford, Blackwell Publishers.

Poulton, E.C., Hunt, G.M., Edwards, R.S. (1978). 'The performance of junior hospital doctors following reduced sleep and long hours of work'. *Ergonomics*, 21: 279-295.

Prondzynksi, F. von (1994) 'Council Directive 93/104/EC Concerning Certain Aspects of the Organisation of Working Time'. *Industrial Law Journal*, 1994, 23 (1): 92-95.

Prowse, P. and Prowse, J. (2007) 'Is there still a public sector model of employment relations in the United Kingdom?' *International Journal of Public Sector Management*, 20 (1): 48-62.
Punch, K.F. (2005) *Introduction to social research* (2nd ed.). London, Sage Publications.

Puwar, N. (1997) 'Reflections on Interviewing Women MPs. Sociological Research Online', 2 (1) <http://www.socresonline.org.uk/socresonline/2/1/4.html> Accessed 14/02/05.

Reinharz, S and Chase, S.E. (2001) Interviewing Women. In J.F. Gubrium and J.A. Holstein (eds.) *Handbook of Interview Research.* CA, Sage.

Reuben, D.B. (1985) 'Depressive symptoms in the medical house officers'. *Arch. International Medicine*, 146: 268. In M. McKee and N. Black (1992) 'Does the current use of junior doctors in the United Kingdom affect the quality of medical care?' *Social Science & Medicine*, 34(5): 549-588, 552-588.

Richards, T. (2007) 'Time to tune into Europe'. *BMJ*, 334: 185.

Richards, T. (2006) 'EU seeks views on patients' rights to care across borders.' *BMJ* (333): 773.

Ritchie, J. And Lewis, J. (2003) (eds) *Qualitative Research Practice: A guide for social science students and researchers.* London, Sage.

Rogers, L. and Carr-Brown, J. (2002) 'Surgeons in rebellion over foreign doctors in the NHS'. *Sunday Times* 2002 July 21:2. In R. Rosen (2002) 'Recruiting overseas doctors'. *BMJ* (325): 290.

Rojot, J. (1998) 'Legal and contractual limitations to working time in the European Union'. *Bulletin of Comparative Labour Relations*, 32: 193– 96.

Rosa, R., Colligan, M.J.,Lewis, P. (1989) 'Extended workdays: effects of 8-hour and 12-hour rotating shift schedules on performance, subjective alertness, sleep patterns, and psychosocial variables'. *Work & Stress*, 1989, 3(1): 21-32.

Rosen, R. (2002) 'Recruiting overseas doctors'. *BMJ* (325): 290.

Royal College of Physicians (2005) *Doctors in Society: medical professionalism in a changing world. Report of a Working Party of the Royal College of Physicians of London.* London, RCP.

Rubin, H.J. and Rubin, I.S. (1995) *Qualitative Interviewing. The art of hearing data. London.* SAGE Publications.

Salter, B. (2002) 'Medical Regulation: new Politics and Old Power Structures'. *Politics*, 22(2): 59-67.

Scallan, S. (2003) 'Education and the working patterns of junior doctors in the UK: A review of the literature'. *Medical Education*, 37: 907-912.

Scheiber, S. (1987) 'Stress in Physicians'. In R. Payne and J. Firth-Cozens, J. (eds.) *Stress in the health professions.* New York, Wiley.

Scheuer, S. (1999) 'The Impact of Collective Agreements on Working Time in Denmark'. *British Journal of Industrial Relations*, 47 (3): 465-481.

Schofield, C. & Schofield, Z. (2005) 'Flexible training for men and women – is this the way forward for medicine? '*BMJ*, 331: 1211.

Schuwirth, L and van der Vleuten, C. (2006) 'Challenges for educationalists'. *BMJ*, 333: 544-46

Scott-Coombes, D. (2002) 'European Working Time Directive for doctors in training. Reduction in juniors' hours abolishes concept of continuity of care'. *BMJ*, 324: 736.

Secretary of State for Wales (1998). *NHS Wales – Putting patients first.* Welsh Office, Cardiff.

Seidman, I. (1998) *Interviewing as Qualitative Research* (2nd ed). Teachers College Press, New York.

Shabbir, M., Amoroso, P., Kirby, R.S. (2005) 'The European Working Time Directive: one step forward, two steps back'. *BJU International*: 727-28.

Shapiro, M. (1987) *Getting Doctored Critical Reflection on becoming a physician.* Philadelphia, New Society Publishers.

Sim, D.J., Wrigley, S.R., Harris, S. (2004) 'Effects of the European Working Time Directive on anaesthetic training in the United Kingdom'. *Anaesthesia*, 59: 781-784.

Sinclair, D. (1997a) 'Self-Regulation versus Command and Control? Beyond False Dichotomies'. *Law and Policy*, 19 (4): 529-560.

Sinclair, S. (1997b) *Making Doctors An Institutional Apprenticeship.* Oxford, Berg.

Smith, J.K. and Heshusius, L. (1986) 'Closing down the conversation. The end of the quantitative-qualitative debate among educational enquirers'. *Educational Researcher* (15), 4-12. In C. Seal (ed.) (2004) *Social Research Methods A Reader.* London, Routledge.

Smith, P. and Morton, G. (2006) ''Nine Years' New Labour: Neo-liberalism and Workers' Rights'. *British Journal of Industrial Relations*, 44 (3): 401-420.

Smith, P. and Morton, G. (2001a) 'New Labour's Reform of Britain's Employment Law: The Devil is not only in the Detail but in the Value and Policy Too'. *British Journal of Industrial Relations*, 39 (1): 119-138.

Smith, P. and Morton, G. (2001b) 'The Conservative Governments' reform of employment law, 1979-1997: 'Stepping Stones' and the 'New Right' Agenda'. *Historical Studies in Industrial Relations*, 12: 131-147.

Snider, L. (1991) 'The Regulatory Dance: Understanding Reform'. *International Journal of Sociology & Law*, 19: 201.

Snyder, F. (1993) 'The effectiveness of European Community law: Institutions, Processes, Tools and Techniques'. *Modern Law Review*, 1: 19-55.

Som, C.V. (2005) 'Nothing seems to have changed, nothing seems to be changing and perhaps nothing will change in the NHS: doctors' response to clinical governance'. *International Journal of Public Sector Management*, 18 (5): 463-77.

Sparks, K., Cooper, C.L., Fried, Y., Shirom, A. (1997) 'The effects of hours of work on health: A meta-analytical review'. *Journal of Occupational and Organizational Psychology*, 70: 391-408.

Spicer, N. (2004) 'Combining qualitative and quantitative methods'. In C. Seale (ed.) (2004) *Researching Society and Culture* (2nd ed.). London, Sage.

Spurgeon A. and Harrington, J.M. (1989) 'Work performance and health of junior hospital doctors – a review of the literature'. *Work & Stress*, 3(2): 117-128.

Stacey, M. (1992) *Regulating British Medicine*. Chichester: John Wiley & Sons.

Strong, P. and Robinson, J. (1990) *The NHS – Under New Management*. Buckingham, Open University Press.

Sullivan, M. (2005) 'Wales, Devolution and Health Policy: Policy experimentation and differentiation to improve health.' *Contemporary Wales*, 17(1): 44-65.

Sullivan, M. (2007) ' Post-devolution health policy'. In Williams, C. (ed.) *Social Policy for Social Welfare Practice in a Devolved Wales*. Birmingham, Venture.

Swick, H.M. (2001) 'Professionalism: A key to weathering the storm'. *Obstetrics and Gynaecology*, 98 (1): 156.

Tallis, R.C. (2006) 'Doctors in society: medical professionalism in a changing world.' *Clin Med*, 6: 7-12.

Taylor, G. (2002) 'Clinical governance and the development of a New Professionalism in medicine: educational implications'. *Education for Health*, 1: 65-70.

Taylor, R. (1998) 'Annual Review Article 1997'. *British Journal of Industrial Relations* 36(2): 293.

Taylor, S.J and Bogdan, R. (1998) *Introduction to qualitative research methods*. New York, John Wiley & Sons.

Teubner, G. (2004) 'Legal Irritants: How Unifying Law Ends up in New Divergences.' In P.A. Hall and D. Soskice (eds.) *Varieties of Capitalism The Institutional Foundations of Comparative Advantage*. Oxford, Oxford University Press.

Thatcher, M. (1993) *The Downing Street Years*. London, HarperCollins, quoted from Blair, A., Leopold, J., Karsten, L. (2001) 'An awkward partner? Britain's implementation of the Working Time Directive'. *Time and Society*, 10: 63-76.

Thorne, M.L. (2002) 'Colonizing the new world of NHS management: The shifting power of professionals'. *Health Services Management Research*, 15 (1): 14-27.

Thornley, C. (1998) 'Contesting local pay: the decentralisation of collective bargaining in the NHS'. *British Journal of Industrial Relations*, 36 (3): 413-34.

Thorpe, P. (2002) 'Implementing the Working Time Directive on a national level'. *BMJ*, 325: 67.

Tomlinson, A. (2005) 'Effects of the EWTD on anaesthetic training in the UK'. *Anaesthesia*, 60: 96-7.

Trimpop, R., Kirkcaldy, B., Athanasou, J., Cooper, C. (2000) 'Individual differences in working hours, work perceptions and accident rates in veterinary surgeries'. *Work & Stress*, 14(2): 181-188.

TUC (2004a) *Changing Times*. Number 38 (17 April).

TUC (2004*b*) *Changing Times*. Number 40 (17 May).

TUC (2003a) 'Work out your unpaid overtime with new TUC calculator - £4,500 is average salary lost'. Press Release, 18 November <http://www.tuc.org.uk/work_life/tuc-7317-f0.cfm> (Accessed 25/11/03).

TUC (2003b) 'It's about time...to end the long hours opt-out'. *Working Life*. November <http://www.tuc.org.uk/work_life/tuc-7285-f0.cfm> (Accessed 10/11/2003).

TUC (2003c) *Working Time Directive Review. The use and abuse of the 'opt-out' in the UK*. London, TUC.

TUC (2002) 'UK workers struggle to balance work and quality of life as long as hours and stress take hold'. Press Release, 30 August <http://164.36.164.20/work-lifebalance/press300802.html> (Accessed 25/11/03).

TUC (2001) 'One in six UK workers put in more than 48 hours a week'. Press Release, 29 January <http://www.tuc.org.uk/work_life/tuc-4277-f0.cfm> (Accessed 30/10/2003).

TUC (2000) *Work smarter an end to burnout Britain*. London, TUC.

Undheim, T.A. (2003) 'Getting Connected: How Sociologists can Access the High Tech Elite'. *The Qualitative Report*, 8 (1): 104-128.

University of London (1991). 'Inappropriate duties for preregistration house officers'. *BMJ*, 302: 570.

Valko, R. and Clayton, P. (1975) 'Depression in internship.' *Diseases of the Nervous Systems*, 36, 26-29. In A. Spurgeon and J.M. Harrington (1989) 'Work performance and health of junior hospital doctors – a review of the literature'. *Work & Stress*, 3(2): 117-128.

Vassallo, D.J., Chana, J., Clark, C.L.I., Smith, R.E., Wood, R.F.M. (1992) 'Introduction of a partial shift system for house officers in a teaching hospital'. *BMJ*, 305: 1005-1008.

Walsh, J. (1997) 'Employment systems in transition? A Comparative analysis of Britain and Australia'. *Work, Employment & Society*, 11 (1): 1-25.

Walshe, K. (2002) 'The rise of regulation in the NHS'. *BMJ*, 324: 967-970.

Wanless, D. (2003) *The Review of Health and Social Care in Wales.* Cardiff, Welsh Assembly Government.

Wanless, D. (2002) *Securing our future health: taking a long-term view, final report.* London, HMSO.

Watson, R. (2007) 'Battles in time'. *BMJ*, 334: 770-771.

Weber, M. (1947) *The theory of social and economic organization.* New York: Oxford University Press.

Welch, C., Marschan-Piekkari, R., Penttinen, H., Tahvanainen, M. (2002) 'Corporate elites as informants in qualitative international business research'. *International Business Review*, 11 (5): 611-628.

Welsh Assembly Government (2005a) *Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century.* Cardiff, HMSO.

Welsh Assembly Government (2005b) *Designed to Comply: Right doctor, right place, right time.* Cardiff, HMSO.

White, M.L., Walker, A., Jackson, E., Thomas, M.L. (2005) 'Impact of the European Working Time Directive on the training of paediatric anaesthetists'. *Anaesthesia*, 60: 870-873.

Wilkinson, R.T., Tyler, P.D., Varey, C.A. (1975) 'Duty hours of young hospital doctors: Effects on the quality of work'. *Journal of Occupational Psychology*, 48: 219-229.

Williams, C. and Cantillion, P. (2000) 'A surgical career? The view of junior women doctors'. *Medical Education*, 34: 602-607.

Williams, C.L. and Heikes, E.J. (1993) 'The importance of researcher's gender in the in-depth interview: Evidence from two case studies of male nurses'. *Gender & Society*, 7 (2): 280-291.

Williams, S.J. (2001) 'Sociological imperialism and the profession of medicine revisited: where are we now?' *Sociology of Health and Illness*, 23 (2): 135-158.

Wilton, J. (1995) 'Pre-registration house officers in general practice'. *BMJ*, 310: 369-72.
Woods, K. (2002) 'Health Policy and the NHS in the UK 1997-2002'. In J. Adams and P. Robinson (eds.) *Devolution in Practice* (IPPR and ESRC).

Worklife Law Program and the Washington Office of the Friedrich Ebert Foundation (2005) *Conference Report – Working time, discrimination and the law: the family responsive workplace in Europe and the United States.* Washington, Friedrich Ebert Stiftung.

World Health Organization (WHO) (1948). *Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the*

World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948 <http://www.who.int/about/definition/en/print.html> (Accessed 09/11/2003).

Yates, S.J. (2004) *Doing Social Science Research.* London, Sage.

Yeager, P.C. (1991) *The Limits of Law. The public regulation of private pollution.* Cambridge, Cambridge University Press.

Yin, R.K. (1994) *Case Study Research Design and Methods* (2nd ed.). London, Sage.

Zucherman, H. (1972) 'Interviewing an Ultra-Elite'. *Public Opinion Quarterly*, 36 (2): 159-175. In N. Fielding (ed.) *Interviewing Volume III.* London, Sage Publications.

Case law

Barber & Others v RJB Mining (UK) Ltd (1999) IRLR 308.

Colson v Land Nordrhein-Westfalen Case 14/83 [1984] ECR 1981.

Costa v ENEL Case 6/64 [1964] ECR 585.

George v Plant Breeding International (Cambridge) Ltd [1991] Case No. 29560/90

Johnston v Bloomsbury Health Authority [1991] IRLR 118.

Landeshaup Kiel v Jaegar C-151/02 [2003] ECR

Marleasing SA v La Comercial Internacional de Alimentacion SA (case C-106/89) [1990] ECR I-4135.

NCB v Galley [1958] 1 WLR 16.

Pfeiffer v Deutsches Rotes Kreisverband Waldshut eV C-397-403/01

R v Attorney General for Northern Ireland, ex parte Burns [1999] IRLR 315.

SIMAP v Conselleria de Sanidad y Consumo de la Generalidad Valenciana and C-241/99 Confederacion Intersindical Galega (C.I.G) v Servicio Galego de Saude SERGAS) C-303/98 [2000] ECR

Tucker v British Leyland Motor Co. Ltd (1978) IRLR 493.

UK v Council of the European Union C-84 [1997] IRLR 30.

Webb v EMO Air Cargo (UK) Ltd [1993] 1 WLR 49.

Legislation

Council Directive No. 93/104/EC of 23 November 1993 concerning certain parts of the organisation of working time.

Directive 2000/34/EC of the European Parliament and of the Council of 22 June 2000 amending Council Directive No. 93/104/EC of 23 November 1993 concerning certain parts of the organisation of working time.

EC Working Time Directive 2003/88/EC of the European Parliament and of the Council of 4 November 2003 concerning certain aspects of the organisation of working time.

The Employment Rights Act 1999.

The Flexible Working (Eligibility, Complaints and Remedies) Regulations 2002 No. 3236.

The Framework Health and Safety Directive 89/591/EEC.

The Minimum Wage Act 1998.

The Working Time Regulations 1998 No. 1833.

The Working Time Regulations 1999 No. 3372.